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# An evaluation of congruency of nursing staff values and organizational Vincentian values

Beverly S. Quaye

Pepperdine University

Graduate School of Education and Psychology

# AN EVALUATION OF CONGRUENCY OF NURSING STAFF VALUES AND ORGANIZATIONAL VINCENTIAN VALUES

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Beverly S. Quaye

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Kay Davis, Ed.D. – Dissertation Chairperson

This dissertation, written by

Beverly S. Quaye

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

May 20, 2009

_____
Kay Davis, Ed.D., Chairperson

_____
Robert Canady, D.B.A.

_____
Louis Rubino, Ph.D.

_____
Eric R. Hamilton, Ph.D.
Associate Dean

_____
Margaret J. Weber, Ph.D.
Dean

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# DEDICATION

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# VITA

Beverly S. Quaye

## Professional Experience

| | |
|---|---|
| Vice President/CNE, St. Francis Medical Center, Lynwood, CA | 2007-present |
| Associate Administrator, USC University and Norris Cancer Hospitals, Los Angeles, CA | 2006-2007 |
| Senior Director, California Regional Team Leader, Operations Excellence, TENET Healthcare, Dallas, TX | 2006-2007 |
| TENET Healthcare Corporation, Dallas, TX | 1997-2007 |
| Operations Improvement Leader, Operations Excellence, TENET Healthcare, Dallas, TX | 2004-2006 |
| Vice President/CNO, Hollywood Presbyterian Medical Center, Los Angeles, CA | 2001-2004 |
| Assistant Chief Nursing Officer, Brotman Medical Center, Culver City, CA | 2000-2001 |
| Nursing Director, Western Medical Center, Anaheim, CA | 1999-2000 |
| Administrator, Tustin Rehabilitation Hospital, Tustin, CA | 1997-1999 |
| Vice President/CNO, Mission Community Hospital, Panorama City and San Fernando, CA | 1996-1997 |
| Nurse Manager, U. S. Department of VA Medical Center, Long Beach, CA | 1995-1996 |
| Nurse Manager (1989-1995), Clinical Instructor (1987-1989), Assistant Nurse Manager (1985-1986), Clinical Nurse (1984-1985), Cedars-Sinai Medical Center, Los Angeles, CA | 1984-1995 |
| Charge Nurse, Century City Hospital, Century City, CA | 1982-1984 |
| Administrative Nurse I, UCLA Hospital and Clinics, Los Angeles, CA | 1977-1979 |
| Staff and Relief Charge Nurse, Mt. Sinai Medical Center, New York, NY | 1976-1977 |

## Other Professional Experience

| | |
|---|---|
| Faculty, Mt. St. Mary's College, ADN to MSN Program, Department of Nursing, Los Angeles, CA | 2009-present |
| Assistant Clinical Professor, UCLA School of Nursing, Los Angeles, CA | 2003-present |
| Advisory Board, Pasadena City College, Pasadena, CA | 2003-2005 |

## Education

| | |
|---|---|
| Ed.D., Organizational Change, Pepperdine University, Los Angeles, CA | 2009 |
| M.S.N., Nursing Administration, University of California, Los Angeles, CA, Magna cum laude | 1994 |
| B.S., Nursing, California State University Dominguez Hills, Carson, CA | 1992 |
| Diploma, Nursing, Medical College of Pennsylvania, Philadelphia, PA | 1976 |

## Licenses and Certificates

| | |
|---|---|
| Executive Nursing Fellow, Wharton Business School, University of Pennsylvania, Philadelphia, PA | 2003 |
| California Public Health Certificate | 1992 |
| California Registered Nurse | 1977 |

## Professional Organizations

Fellow, American College of Healthcare Executives
Member, Sigma Theta Tau International Honor Society of Nursing
Member, Healthcare Association of Southern California, Nurse Executive Council

# ABSTRACT

This case study was an exploration of values-congruence between personal and organizational values in a healthcare setting. Previous research has found that alignment between the two improves organizational effectiveness. The setting was a 384-bed urban Catholic hospital with Vincentian values. The efficacy of Vincentian values is found only in the academic and religious literature, not in that of healthcare. Published studies on registered nurses' values focus primarily on ethical reasoning and decision making.

Employee values were defined using Rokeach's conceptual model for instrumental and terminal values. Both are based on enduring beliefs with specific modes of conduct or end-states of existence and are personally and socially preferable. A small ($N$ = 27) sample of nurses completed an electronic survey. Demographics included age, gender, religion, and ethnicity. Organizational values were defined as the 5 Vincentian values of the sponsoring health system.

Results revealed consistency between the survey tool's instrumental and terminal values and Vincentian values (17 of 36), and alignment with the organizations' values measured in high (9 of 17) and moderate (5 of 17) levels. There were varying levels of congruence between the nurses' personal values and the organizational values. The values of self-respect, capable, helpful, honest, loyal, and responsible had high levels of congruence. Equality, family security, broadminded, courageous, forgiving, and loving had moderate levels of congruence, and inner harmony had low congruence. Few differences were found among the demographic subgroups within the sample.

Recommendations for the organization include more extensive values assessment to enhance organizational effectiveness for future leadership strategies and management direction. Support for values-based patient/family-centered care, such as tool development for goal achievement, competency evaluation, staff development, planning for healthcare services, and program development are the desired end products.

Recommendations for further research include assessing the relationship between Vincentian values and other key areas, including communication, management decisions, leadership, ethical decision making/judgment, and patient care quality and safety. The avenues for study of Vincentian values in healthcare are almost as endless as the challenges and opportunities in healthcare today.

# Chapter 1

## Issue

At no time in U.S. history has healthcare been in a worse state, and problems associated with healthcare are worsening at an escalating rate. In 2005, total national healthcare expenditures rose 6.9% to $2 trillion or $6,700 per person—16% of the gross domestic product (GDP) (Catlin, Cowan, Heffler, & Washington, 2006). Healthcare spending is four times the amount spent on national defense (California Healthcare Foundation, 2005). With the advent of our country's new administration under President Barack Obama, there is hope. However, to realize such hope, we need to see significant reform in healthcare organizations, i.e., hospitals, which continue to struggle to provide quality care, satisfy community needs, retain qualified and compassionate healthcare practitioners, and balance cost efficiencies. As hospitals try to meet these challenges, they frequently experience organizational ineffectiveness.

Among the factors that contribute to poor organizational functioning are declining reimbursements largely due to rising numbers of uninsured patients, increased labor costs, quality issues, growing consumer demands, and healthcare practitioner shortages. A local, national, and international nursing shortage, staffing pressures driven by mandatory staffing requirements in California, and increasing labor union representation of registered nurses are among the many contributors. These factors, in particular, often shift the focus of the registered nurse from patient care to personal demands and needs.

In this regard, Maslow (1970) proposed a developmental hierarchy organized into five categories of human motivators or needs. The categories, in ascending order, are: (a) physiological needs, (b) safety and security, (c) belongingness and love, (d) esteem, and

(e) self-actualization. The shift in the focus of the registered nurse from patient care to personal demands and needs moves them down the hierarchy and into the survival mode. Once a registered nurse is in the survival mode, he or she will not be able to focus on or care for other higher level needs (Maslow, 1968). In addition to sacrificing patient care, registered nurses may also experience reduced productivity; delays in treatment; failure to follow nursing policy, practice, and protocols; errors; increased lengths of stay resulting in quality of care issues; patient dissatisfaction; and low employee (associate) morale as a result of the lack of patient focus, owing to survival mode status.

Due to these factors, nurses are charged with delivering care in a very stressful environment. This stress may be affecting the way they think and feel in the practice setting and could be contributing to their suboptimal job performance that, in turn, affects patients and the organization's overall performance, as measured by operational, quality, and service measures.

Some nurses, however, thrive and continue to provide quality care despite this difficult environment. One explanation might be that nurses' values affect behavior and ultimately patient outcomes more than do external pressures. Perhaps the thoughts and feelings that are produced from this crisis-like setting day in and day out can cause some nurses to lose touch with the beliefs and values that led them to selecting a caring profession in the first place. If this is the case, then nurses' rediscovery of core beliefs and values could, in turn, affect their feelings and thoughts, thus re-focusing their attention and actions on the care of the patients rather than on the dysfunction of the healthcare system. Perhaps this could ultimately improve patient care and outcomes.

Values have been defined in a variety of ways. Kluckhohn (as cited in Fritzsche & Oz, 2007) defined a value as "a conception, explicit or implicit . . . of the desirable which influences the selection from available modes, means, and ends of action" (p. 3). Fritzsche and Oz (2007), Krech, Crutchfield, and Ballachey (1962), French (1969), French and Bell (1995), and Krech, Crutchfield, and Ballachey (1962) made the following distinctions between beliefs and values: (a) beliefs are propositions about how the world works that the individual accepts as true and is a cognitive fact for that person, and (b) values are beliefs about what is a desirable or good and what is undesirable or bad.

Rokeach (1973) is responsible for the concept that a value is an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence. Nystrom (1990) believes that values are normative beliefs about proper standards of conduct and preferred or desired results and concluded that an organization benefits from an institutionalization of moral values into the basic assumption about how to conduct operations. Schwartz (1992) concluded that values are desirable, are related to situational goals, vary in importance, and serve as guiding principles in people's lives.

Beliefs and values provide a structure as well as stability for others as they attempt to understand the world around them, in this case, the hospital workplace. Aside from differing definitions of values, there is general agreement that values influence behavior. Values are drivers of behavior (Rokeach, 1973), including workplace behavior (Schwartz, 1992). In healthcare, there is an assumption that values are the criteria for providing patient care and not merely qualities inherent in individuals. Values provide the

basis for the development of individual beliefs that lead to decision making (Conner & Becker, 1979). Fritzsche and Oz (2007) determined that values play an important role in the ethical dimension of decision making. Campbell, Dunnette, Lawler, and Weick (1970) developed the values expectancy model that proposes that people will expend effort to achieve goals that they believe will result in outcomes that they desire. Because clinical care and practice involve ethical decision making and are outcome-driven, the values expectancy model is relevant to the quality of healthcare.

There is an overwhelming complexity of the issues facing hospitals today. Some of the factors that affect the effectiveness of an organization are external and uncontrollable. Intrinsic factors, i.e., the values of nurses, however, may have a significant impact on clinical outcomes. One possible solution to improving hospital organizational effectiveness is to assess the internal values of the nursing staff and address these issues from the inside out.

Nursing comprises over 50% of a hospital's average costs and nurses make up the majority of the workforce (Carter, 2000). Nurses also have a profound effect on hospital performance because they define and coordinate care for their patients day and night, 7 days a week. This is why nursing services are a key factor in the cost, quality, and provision of patient care. Importantly, nurses' values, and their alignment with those of the organization, most likely have a direct impact on the quality of care and services rendered.

### *Statement of the Problem*

As California hospitals have suffered a steady decline in operating margins, nurses are faced with delivering care that meets increasing demands from the

government, patients, and physicians to provide higher quality outcomes. In Los Angeles County, these challenges have escalated to a critical level, and the hospital that is the focus of this study operates in a chronic state of crisis. The problem under study is directly related to the critical changes that have occurred in the work experience of the nurses at this hospital, which is a Catholic institution that is based on the mission and values of St. Vincent de Paul.

The stressors of the nursing environment may have led to a loss of focus on the Vincentian mission and values of the local health ministry. This may be contributing to the dissatisfaction in patients and employees as demonstrated by increased patient complaints and union grievances. Although some research on the application of Vincentian values is documented in the literature on educational settings (Bowes, 1998; Brezler, 2001; Clark, 2001; Dumbleton, 2005; Fuechtmann, 2005; Holtschneider, 2005; Marques, 2005; McCann, 2005; McKenna, 2005; McNeil, 2005; Mousin, 2005; Murphy, 2005; Posig, 2005; Tavanti, 2005, 2006; Tavanti & Kelley, 2007; Udovic, 2005; Worral, 2005), there is little research on such values in healthcare settings.

### *Purpose of the Study*

The purpose of this case study was to assess whether congruence existed between nurses' personal values and the organization's Vincentian values. By completing an assessment and determining which values have congruence with the organization's values, the findings could serve as the foundation for the design of a new clinical care delivery model, tools, and staff development strategies that will transform the nursing practice culture within the organization. The model's components would be based on a values-centered care framework, specifically patient-family centered care. Providing

values-centered care in a purposeful manner often contributes to a sense of meaning to one's work. Meaningful work in turn contributes to enhanced levels of personal satisfaction, promoting higher levels of engagement in the workforce, and is likely to result in improved quality of patient care and better nurse satisfaction overall. The study's purpose is illustrated in Figure 1.

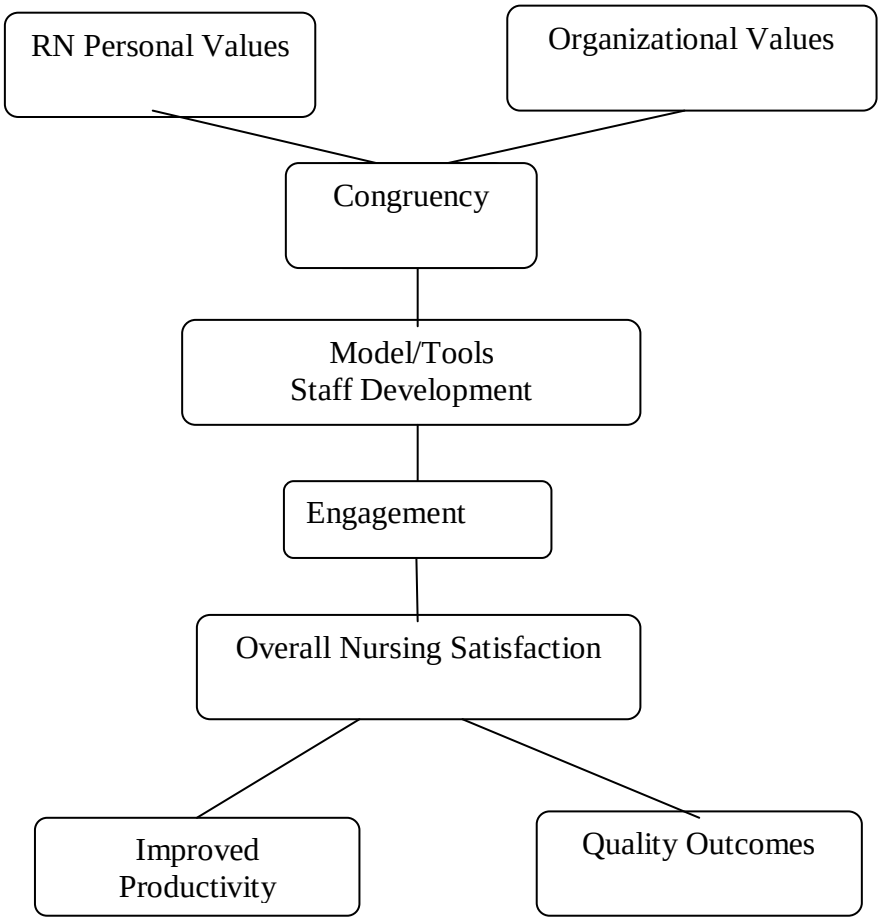


*Figure 1.* Purpose of the study.

*Background and Overview*

Mission and values are critical aspects of an organization's effectiveness during periods of stress and rapid change, such as what has been described in hospitals. These challenges are even more difficult to overcome for a faith-based hospital located in a poor, underserved community in Southeastern Los Angeles, where many residents are uninsured, lack education, and do not have the means for preventive care. The research setting is Saint Francis Medical Center (SFMC), a local health ministry of the Daughters of Charity Health System. Their founders, St. Vincent de Paul, St. Louise de Marillac, and St. Elizabeth Ann Seton created a mission to serve the sick poor, which continues to be the central mission of the medical center today.

The area of interest of this particular case study is to evaluate whether nurses' values are congruent with the Vincentian values of this Catholic hospital, which has incorporated them into its mission of serving its community. Vincentian values include respect, compassionate service, simplicity, advocacy for the poor, and inventiveness to infinity. Vincentian institutions carry a responsibility for the continuation of the Vincentian character and mission and, due to the declining number of the religious, require increasing numbers of laity to assume more leadership roles. To continuously renew Vincentian culture with religious and lay people, individuals need to be inspired and committed to the higher purpose of their Vincentian institution. In addition to looking at the problem being addressed from a faith-based perspective, it is also critical to understand why healthcare and hospitals are important on several levels.

*History of Hospitals in the U.S.*

There are 5,756 U.S.-registered hospitals. Staffed beds in those hospitals total 946,997 (American Hospital Association, 2007). According to the American Hospital

Association, 37 million were admitted to hospitals in 2005, and 30% of the nation's annual healthcare expenditure is for the care of hospitalized patients, the highest level of care in our healthcare delivery system (U.S. Department of Health and Human Services, 2007). Although change continues to occur in healthcare delivery, driven in part by changes in payment policies, advances in technology, and more complex treatments performed in outpatient settings, hospital inpatient utilization remains stable and still plays a large role in the technical aspect of the management of accidents, trauma, illness, and disease in general. Outpatient surgeries rose from 51% to 63% from 1990-2004, and age-adjusted average length of stay for inpatient hospitalization has remained constant, at 4.8 to 9 days, from 2000 to 2004 (U.S. Department of Health and Human Services, 2007). Economic factors and societal attitudes regarding the health and welfare of individuals and communities have influenced and will continue to influence the evolution of hospitals.

*Faith-based.* Many spiritual and sacred orders have been committed to the care of the sick. The Catholics began a mission-driven ministry that was initiated by Elizabeth Ann Seton's work in conjunction with her father and brother, both physicians in the early 1800s. She later founded the Sisters of Charity who, in 1823, in partnership with University of Maryland physicians, began the Baltimore Infirmary (Gilbert, 2007). Many of the sisters' visits to the sick in other locations led to modestly built structures or first hospitals across the country. Today, Catholic hospitals account for the largest percentage of mission-driven hospitals, with a religious focus at 16% of their community hospitals or a $1.54 trillion-a-year industry (Jones, 2003). Many other religious orders also have made significant contributions to care of the sick.

*State of Crisis—Economic, Societal, and Personal Concerns*

*Economic concerns.* According to a recent report of the U.S. Department of Health and Human Services (2007), the U.S. spends a larger share of its GDP (16%) on health than does any other major industrialized country. The next closest is Switzerland, at 10.9%. Healthcare expenditures have increased nearly 7% or two times the rate of inflation. To put this into perspective, from 1993 to 2003, health expenditures rose from approximately $900 billion to $1.7 trillion (Zuckerman & Joshua, 2006) and continue to rise. U.S. healthcare expenditures are predicted to continue to rise at similar levels for the next several years, reaching $4 trillion by 2015, or 20% of the GDP (Borger et al., 2006).

In addition to public health expenditures increasing, private health expenditures also continue to rise. These expenditures often can be explained by the growing numbers of uninsured, who continue to pose a huge societal issue. Even though over $2 trillion is spent on healthcare every year, over 47 million people in this country lacked insurance of any kind in 2006 (Employee Benefit Research Institute, 2008). One in six, or 18%, of all Americans under 65 did not have health insurance in 2006. Moreover, between 2000 and 2006, the number of uninsured grew by 9.4 million in the U.S. According to national surveys, this growth is due to the high cost of health insurance (Hoffman, Schwartz, & Tolbert, 2007). When faced with providing basic needs for their families, many find health insurance unaffordable. The annual premium that a health insurer charges an employer for a health plan covering a family of four averaged $12,106 in 2006 and employee contributions, averaging $3,281, outpaced workers' earnings and inflation (Kaiser Family Foundation and Health Research and Educational Trust, 2007).

Employers, who were the main providers of health insurance during the latter half of the 20th century, are cutting back on their provisions for health insurance due to the spiraling costs of benefits. Those without insurance are often faced with exorbitant cash rates for healthcare, a lack of awareness of financial options available, and frequent avoidance of healthcare, which delays treatment and medication regimens. Consequently, the vast numbers of uninsured have a dramatic impact on the emergency departments and available acute beds in U.S. hospitals, creating crisis situations on a daily basis. Hospitals are required to treat all individuals requiring emergency care and stabilization regardless of documentation or legal status. If the sick poor are not eligible for governmental assistance, then they become charity care. These economic issues are often a result of the broader societal issues that we are presently facing in the U.S. A brief look at some of these issues that affect our communities will broaden our understanding before proceeding to how our individual citizens are affected.

*Societal concerns.* Sometimes stepping back to take a broader look at societal values puts things into context so that we may develop a deeper understanding of how the healthcare crisis has evolved. Current healthcare issues are consistent with other societal maladies that our country is facing, related to individual attitudes and values that collectively add up to the problems of our society at large.

There is a social incongruence between our consumer-driven values that focus on accomplishments and acquisitions and a concern for the overall well being of ourselves as a people, our environment, our resources, and our sustainability for future generations. The U.S. has 5% of the world's population but consumes 30% of the world's resources (Seitz, 2001) and creates 30% of the world's waste (Harris, 2004). These statistics

reinforce that we are a consumer society that has a "getting-and-spending" mindset. In fact, the average U.S. citizen now consumes twice as much as was consumed 50 years ago (Taylor & Tilford, 2000). This is important because the employees who comprise our healthcare workforce and often work in our mission-driven organizations also have this materialistic mindset in common, whereby SUVs, large homes, and designer purchases stand in contrast to a more humanitarian focus of striving for achieving the common good for mankind of caring, healing, and restoring well-being.

A faith-based institution with a strong mission is counter-cultural to today's societal norms and to the growing gap between the affluence that drives consumption and the large numbers of poor and homeless in our urban areas who are frequently sick as a direct result of a lack of food, shelter, and healthcare. These problems are created by social choices and result in moral dilemmas. We may even walk past such individuals on our streets, often with shame and guilt; yet rarely does this change our behavior. In *Habits of the Heart: Individualism and Commitment in American Life*, Bellah, Madsen, Sullivan, Swidler, and Tipton (1985) describe this societal symptom as "rugged individualism" and believe that this is what often makes it difficult for people to sustain their commitments to others. This concept is transferable to nursing and the caring of others. Bellah et al. believe that we (values) are formed by opportunities and barriers that the greater society (including organizations) present to us.

Often institutions are founded on traditional truths, i.e., religion, and democracy, but Americans struggle with understanding how those traditions apply to their lives today. On an organizational level, Bellah, Madsen, Sullivan, Swidler, and Tipton (1991) argue that institutions need to be altered or reformed to reflect new norms that will

strengthen institutions' changing their definition of themselves and their communities, and how they respond to major challenges. Bellah et al. (1991) believe that, because institutions involve patterns of social activity, they give shape to collective and individual experiences, guide and sustain individual identity, support behaving and relating to others in certain ways, shape character, assign responsibility, demand accountability, and provide standards for reward and recognition.

There is a gap between *technical reason*, whose basis is knowledge, and *moral reason*, whose basis is values in our society (Bellah et al., 1991). "As the power of our ability to manipulate the world grows, the poverty of our understanding of what to do with that knowledge becomes more apparent" (p. 429). This concept is important as it provides meaning to this case study, which examines whether individual values are congruent with organizational ones.

Organizations that are mission-driven are often challenged with societal incongruence because the expectations of its employees are divergent from their own values and beliefs. Our collective values have changed over time, and we have lost focus on non-material activities. On a personal level, when things are going well in life, people rarely think of healthcare. However, when a healthcare crisis occurs, thinking changes and individual demands increase. Cooper (1986) discussed the macrocosmic view of Americans, who are willing to accept limits in the medical system to achieve lower cost; however, on a microcosmic level, they often feel very different when it comes to themselves or loved ones faced with a few months to live or a minute chance of a cure, i.e., personal concerns.

*Personal concerns.* The U.S. Department of Labor and Bureau of Labor Statistics reports in detail the impact that healthcare issues have had on Americans on a personal level. Total consumer expenditures were, on average, $49,638 per consumer unit in 2007, with healthcare being the fifth major expenditure, or a 3.1% increase over the previous year (U.S. Department of Labor, 2008). On a more optimistic note, the healthcare profession is the livelihood of millions of Americans. According to the U.S. Department of Labor and Bureau of Labor Statistics, healthcare is the largest industry in the U.S., providing 13.5 million jobs (U.S. Bureau of Labor Statistics, 2007). Of the occupations projected to grow the fastest, 8 out of 20 are in healthcare. New wage and salary jobs in healthcare will account for approximately 3.6 million jobs between 2004 and 2014. Hospitals constitute only 2% of all healthcare establishments, yet they employ 40% of the healthcare workforce. This largely is due to the complexity of services but also the nature of an around-the-clock operation. Three out of 10 hospital workers are registered nurses, and employment in healthcare is projected to continue to grow as the population's larger number of older adults with subsequent greater-than-average healthcare needs grows.

Several factors have been discussed that contribute to the overall healthcare crisis in the U.S. from a national perspective. Next, the healthcare crisis from a state level is presented, followed by a brief description of the pressing healthcare issues in Los Angeles County to provide contextual background.

### *California Healthcare Issues*

*California.* According to the California Hospital Association (CHA), nearly 50% of California's community hospitals are operating in the red, and nearly one-third are in a financial category equivalent to junk bond status (California Hospital Association, 2008).

The state has the largest uninsured population in the nation, totaling 6.8 million. The CHA also noted the significant underfunding of government programs, currently totaling a $5.4 billion shortfall and ongoing emergency room closures that are putting additional pressures on hospitals and patients. There are severe workforce shortages, especially among registered nurses. California ranks 49 out of 50 in registered nurses per capita, with 545 nurses for every 100,000 patients. Different from other states, California is faced with a $110 billion seismic safety mandate, with no financing mechanisms for hospitals.

*Los Angeles County.* Los Angeles County has some unique challenges; 23.5% of the total population ages 0-64 were uninsured during all or part of 2005, with only 48.8% having employment-based insurance all year. The county is home to over one-third of the state's uninsured residents. According to the California Health Interview Survey 2005, 307,000 uninsured children and 1,823,000 non-elderly adults reside in Los Angeles county, compared to 1.1 million uninsured children and 5.4 million uninsured adults statewide (UCLA Center for Health Policy Research, 2007).

Weissman, Stern, Fielding, and Epstein (1991) found that individuals with better access to healthcare are more likely to receive better quality care and outcomes. Expanding the healthcare safety net has been shown to improve access to care by providing a usual source of care (Roby, Kominski, & Cameron, 2007). Notably, 7.6 million Californians rely on the safety net of healthcare providers for regular care historically serving lower income adults, children, racial/ethnic minorities, and immigrants (Gatchell, Lavarreda, & Ponce, 2007). In addition to these economic issues,

there has been a significant reduction in healthcare services in Los Angeles County that is relevant to this case study.

Beginning in 2004, Martin Luther King Medical Center (MLK), a Los Angeles County healthcare facility in Southeastern Los Angeles, was determined to have significant quality-of-care deficits. All acute care services and emergency services were closed to the community between 2004 and August 2007. There were nine hospitals that absorbed the paramedics' runs and admissions from that service planning area due to its reduction/closure in services. According to a National Healthcare Foundation analysis, volume and/or the intensity of service caused capacity issues in all nine area hospitals in their emergency rooms often due to the utilization of non-emergency outpatient care by uninsured patients (Lott, 2008). SFMC is the closest of the nine facilities. In addition to MLK's closure, five private community hospitals closed around the same time, causing further demand on emergency departments and acute care services, resulting in long wait times, bed capacity issues, and overall throughput issues (Lott, 2008). Subsequent to these critical changes, heavier workloads and increased security needs, due to a changing patient demographic, were required at SFMC. Gang- and violence-related crimes have required Los Angeles sheriff-on-site services in many situations.

### *Significance of the Study*

This study is significant in several ways. First, the results will contribute to the current limited body of knowledge on registered nurses' values when working in a highly mission-driven, faith-based setting. Such knowledge has the potential to facilitate change for similar faith-based healthcare organizations. As has been noted, there is limited research in this area; most nursing research has focused on clinical delivery of care and

nursing management. Further, the majority of writing and research on Vincentian values has been conducted in religious and academic settings (Bowes, 1998; Brezler, 2001; Clark, 2001; Dumbleton, 2005; Fuechtmann, 2005; Holtschneider, 2005; Marques, 2005; McCann, 2005; McKenna, 2005; McNeil, 2005; Mousin, 2005; Murphy, 2005; Posig, 2005; Tavanti, 2005, 2006; Tavanti & Kelley, 2007; Udovic, 2005; Worral, 2005). Because the organizational values are spiritual (religious) in nature, it is important to also note that, in the last decade, there has been increased academic interest and research in spirituality in the workplace as a force that drives organizations. Little, however, has been codified in operational terms by practitioners (Giacalone & Jurkiewicz, 2003; Gilley, Quatro, Hoekstra, Whittle, & Maycunich, 2001; Neal, 1997, 2000; Porth, McCall, & Bausch, 1999; Quatro, 2002, 2004; Vaill, 1998).

Second, there is a demand for information and empirical validation about what behavioral criteria can be used to enhance job performance in the delivery of patient care in terms of spirituality; in this case, specifically Vincentian values. Quatro (2004) believes that the holistic engagement of an increasingly sophisticated and evolved workforce ultimately leads to more satisfied and productive human resources, which ultimately improves performance. Although today's healthcare experts agree that achieving optimal patient care outcomes is critical, progress is slow and most data available are from performance improvement methods. More public attention is currently focused on healthcare misuse and error than on the effect that mission and values may have on patient outcomes (Beardsley & Woods, 1999; Gawande, 2007; Kenney, 2008; Leape & Berwick, 2005; Page, 2004; Wachter, 2008; Wachter & Shojania, 2005). There

is very little research on how to make these behavioral process changes in hospitals to achieve optimal results.

Third, the knowledge gained will be useful for hospital leaders as well as the religious and lay ministry in terms of ways to increase the effectiveness of clinician engagement in a Catholic healthcare environment. As the religious advance in age and fewer Americans are choosing religious vocations, developing a lay ministry is critical to sustaining the mission of this particular health system and other Catholic ones as well. The results of this study may contribute to the development of a lay ministry in Catholic healthcare settings.

Finally, for hospitals that have been through a values change facilitation process, learning takes place on a multitude of levels. The results of the research provide information that can help improve both human capital and processes. The results may help hospitals to understand how to utilize internal resources more effectively and could lead to more successful strategic planning and program implementations in the future. The ultimate outcome of this study is that overall patient care measurements and mission scores will improve, and healthcare users will benefit from better patient care and healthier communities.

### *Conceptual Approach*

The literature that forms the conceptual foundation of this study includes the following key areas: (a) values formation and impact on human behavior; (b) nursing values and effect on patient care; (c) organizational values in relation to organization effectiveness, including Vincentian mission and values; and (d) values congruence. The pervasive nature of new knowledge and subsequent change often presents a challenge to

all levels of leadership in achieving organizational effectiveness. Mission and values theory research contributes a wealth of knowledge that can lead to changes in approach and leadership strategy that often lead to desired behaviors and improved clinical performance.

*Definition of Terms*

*Values.* (a) a *value* is something (as a belief, principle, or quality) intrinsically worthy or desirable; (b) *Vincentian* values are of or pertaining to the Roman Catholic Congregation of the Mission founded by St. Vincent de Paul in Paris, France, in 1625 and devoted to missions and seminaries; (c) *instrumental* values are a category of values identified by Rokeach (1967) as being a "mode of conduct;" (d) *terminal* values are the other category of values identified by Rokeach as being "end-state" values; (e) *mission* is a ministry commissioned by a religious organization to propagate its faith or carry on humanitarian work; and (f) *congruence* is the quality or state of agreeing, coinciding or being congruent (*Merriam-Webster,* 2007).

*Hospitals.* (a) *case hospital* is Saint Francis Medical Center (SFMC) and is managed by the *Daughters of Charity* (DOC) community of Catholic women whose vocation is devoted to living in a community of apostolic life and whose mission follows in the footsteps of St. Vincent de Paul, St. Louise de Marillac, and St. Elizabeth Anne Seton; (b) *Daughters of Charity Health System* (DCHS) is a healthcare system comprised of five faith-based hospitals throughout California; (c) *local health ministry* (LHM) is a term used by DCHS that is synonymous with hospital; (d) *faith-based institutions* are centers or areas of operation/mission based on belief with strong conviction and trust in and loyalty to God; (e) *organized charity* is benevolent goodwill, love, generosity,

helpfulness and aid to the needy and suffering administered by a formal process and structure; and (f) healthcare *safety net* includes those institutions which, either by legal mandate or explicitly adopted mission, serve patients regardless of their ability to pay, and whose patient mix includes large numbers of uninsured, Medicaid, and other vulnerable patients (Institute of Medicine, 2000).

### *Summary*

Healthcare is in turmoil and community hospitals in urban areas bear the major burden of care for the impoverished, the uninsured, and the underserved. Research was cited that shows the breadth and complexity of the problem from a variety of perspectives, including economic concerns. Hospitals spend a great deal of money on maintaining a competent and steady clinical nursing department, which is essential for delivering both efficient and quality healthcare to the public. It is believed that a discontinuity between a nurse's value system and organizational values may contribute to less than optimal patient care, resulting in higher economic as well as social and personal costs.

Based on this, the purpose of this study was to understand the values of the primary care providers, registered nurses, and hospitals and to examine whether they are congruent within this faith-based, values-oriented environment. The assumption is that, if there is congruence, excellence in quality of care and service will be achieved. The review of related literature pertinent to this study focuses on how personal values direct behavior and how, specifically, nursing and organizational values can contribute to organizational effectiveness in hospitals for which values congruence is achieved. Vincentian mission and values are also presented and discussed.

# Chapter 2

## Review of Related Literature

Locke, Spirduso, and Silverman (2000) stated that a literature review serves two purposes: "(a) why the research was formulated, and (b) why the proposed research strategy was selected" (p. 68). By providing an explanation of the conceptual framework, supported by the literature, the aim of this chapter is to provide a conceptual foundation for the study. This foundation served as the organizing basis for this literature review, which includes the following key areas: (a) values formation and its impact on human behavior; (b) nursing values and effect on patient care; (c) organizational effectiveness in relation to organizational values, including Vincentian mission and values; and (d) values congruence.

The practice of healthcare delivery in hospitals and the structure of the healthcare system in the U.S. are undergoing deep, broad, and rapid change. Traditional clinical practices and attitudes that may have been standard in previous eras are ineffective today. Values-centered care may be a solution that will strengthen organizations to keep pace with both internal and external changes in the hospital setting.

### *Values Formation and Human Behavior*

Values are often defined in a variety of ways, yet there is general agreement that values influence behavior. Values provide the basis for the development of individual beliefs that provide individuals with a framework to understand their world. Values bring significance to our lives and are reflected through the priorities that we choose and act on in a consistent manner. Individual or personal values evolve from circumstances within the external world that develop early in life.

In the early 1980s, values were beginning to be seen as a type of social cognition that facilitates an individual's ability to adapt to the environment (Kahle, 1983). Groups, societies, or cultures develop group or communal values that are often largely shared by their members. Although values are fairly resistant to change, they can change over time.

From a social perspective, values are developed from one's experience in the environment and are influenced by one's family, nation, generation, historical and political events, culture, and religion. There are three periods of values development: (a) imprint, (b) modeling, and (c) socialization (Massey, 2008). The imprint period is from 0 to 7 years of age and involves learning from our parents. During this stage, the individual accepts much of what is taught to him or her as true and develops a sense of right versus wrong and good versus bad. The modeling period is between ages 8 and 13, during which the individual learns to copy parents, teachers, and other prominent people in his or her life. The last period, between ages 13 and 21, is the socialization period, during which one is largely influenced by peers and others who seem most like the individual. Individuals in this age group are also easily affected by the media.

Rokeach's (1973) work has demonstrated that values drive behavior. Schwartz (1994) argues that individual norms and values can lead individuals to act altruistically even in situations where such behavior contradicts the narrow interests of the individual. This is often the case in extreme situations that result in heroic acts. When researching the role that personal values play in decision making within an organization, Fritzsche and Oz (2007) found a significant positive contribution of altruistic values to ethical decision making and a negative contribution of self-enhancement values to ethical decision making. A values shift to a different developmental phase of life may involve

belonging to a community or institution as is demonstrated in some specific vocations and professions (Hall, 2006). Hall stated that "values can be chosen consciously and measured, and can become a tool that allows us to choose a new set of futures" (p. 14). This concept is pertinent to this study as communal values apply to nursing because it is often viewed as a vocation and a profession.

*Nursing Values and Effect on Patient Care*

Frederick, Wasieleski, and Weber (2000) conducted an extensive database survey of empirical research on values, ethics, and moral reasoning of healthcare professionals and determined that the majority of existing research has focused on ethics and moral reasoning as opposed to values. Although representative of nursing values research, it is most commonly tied to ethics and moral judgment and the development of normative theory and concepts (Omery, 1989; Raines, 1994; Thurston, Flood, Shupe, & Gerald, 1989; Viens, 1995). Omery demonstrated that values and moral reasoning could be identified through empirical research and serve as guides for moral and ethical decisions. Raines differentiated individual values from the study of ethics but did not discuss the application of ethics principles to daily practice. Raines did state, however, that values are the mechanism used by the individual for choosing alternatives and for identifying the right actions in a situation.

Other research focused on the contrasting depth of values shown between nursing faculty and nursing students and related nursing values to value transformations occurring in society at large (Thurston et al., 1989). Viens' (1995) nurse practitioner study identified values as essential features of moral reasoning, with an emphasis on the contextual nature of nurses' approaches to moral dilemmas. There is virtually no

research, however, on linking values to everyday practice where normative decisions literally make the difference between life and death.

Values-centered care is a result of connecting the personal mission and values of its associates (nurses) with the alignment of those of the organization. There has been, however, little interest in identifying, describing, or analyzing the values of healthcare professionals and their alignment to their organizations' values. This is an important area because, to consistently achieve excellent patient outcomes, one must first determine whether nurses' values affect their behavior despite environmental pressures. A values-centered nursing workforce is emblematic of the DCHS mission statement: "We promote a just society through value-based relationships" (Daughters of Charity Health System, 2007, para. 6). In the hospital setting, a nurse cannot provide quality care and service if it is not based on his or her ability to translate personal values into clinical practice by forming an effective nurse-patient relationship.

Blanchard and O'Connor's (1997) work on managing by values recognizes that every organization is facing increasing complexity, competitive challenges, and a high rate of change, calling for a new and broader approach to organizational effectiveness based on mission and values. This is relevant to the hospital under study because values-centered nursing care, or "caring by values," can be likened to managing by values. Covey (1990) described not being able to transform an organization until personal character and interpersonal relations based on principles are built. People (nurses) will not adapt to external reality or willingly change with commitment and desire until they sense internal security. Effective facilitation is needed to influence nurses' attitudes and values, motivate and refocus them on their patients' care, and contribute to nurses' job

satisfaction. Cohan's (2003) foundation for value-based work is based on people (nurses) being communal creatures who derive satisfaction from achieving their own goals and from helping others.

Campbell et al. (1970) has studied how rewards affect both individual and group performance. Campbell et al.'s values expectancy model proposes that associates expend effort to achieve goals that they believe will result in the outcomes that they value. Effort results in the desired performance goals if the goals are realistic, if associates fully understand what is expected of them, and if there are necessary skills and resources to accomplish aims. Because nursing care and practice are outcome-driven, Campbell et al.'s model is consistent with clinical patient care in hospitals. Nurses who ascribe to values-centered care can drive the change required to achieve superior performance.

*Organizational Effectiveness in Relation to Organizational (Vincentian) Values*

There are numerous ways to conceptualize and model an organization, which largely affects its criteria for effectiveness. Organizational effectiveness is contextual and is typically based on organizational form and structure as well as organizational function and activities (Morgan, 1997). For example, in the 19th and early 20th centuries, organization and management theories were comprised of reductionism, determinism, and equilibrium as the core principles of the organization, which was seen as a "machine" with management's emphasis on control and authority. In contrast to the latter part of the 20th century and the current century, with the development of technology and complexity, an adaptive self-organizing systems model has shifted management's focus to organization-external environment interactions; collaboration; associate motivation; and

the dynamic aspects of change, adaptation, and learning (Morgan, 1997; Wheatley, 1992).

Consistent with this view, Quinn and Rohrbaugh (1983) recognize that focusing on generic functions is no longer appropriate when analyzing an organization. They developed four models of organizational effectiveness: (a) human relations model, (b) open systems model, (c) rational goal model, and (d) internal process model. They concluded that effectiveness depended upon the ability of an organization and its managers to strike the right balance among these attributes as required by the organization's objectives and situation. Up until the quality movement, critical performance attributes largely focused on management processes, but in the 1980-1990s, there was a shift to focus on production processes and process improvements (Hammer & Champy, 1994; Juran, 1988; Lawler, Mohrman, & Benson, 2001).

Hospitals typically operated as closed systems that had an internal perspective but, with the quality movement and the addition of public data reporting in recent years, measuring organizational effectiveness in hospitals has rapidly changed. The balanced scorecard approach to performance measurement is the best way to assess organizational effectiveness in most hospitals. Created by Kaplan and Norton (1996), the scorecard prototype not only defines a particular strategy but also how the strategy is to be implemented. The changes in healthcare and its measurements have given rise to new performance functions such as change management, organizational learning, knowledge management, organizational partnerships and networks, and innovation and creativity. This has necessitated the use of a more open-systems approach.

Typical measures of organizational effectiveness include productivity, profitability, turnover, quality metrics, customer satisfaction, associate satisfaction, and efficiency/throughput measures, i.e., turnaround time of key processes. Measurement allows for management, which can help an organization guide and direct its valuable human capital toward the goals that it has identified. Measurement of an organization's effectiveness can be an issue because a significant portion of the service sectors in the economies of developed nations relies on knowledge and human capital. Although a hospital has many outcome measures that they analyze, associates' knowledge, and in this case values, is not typically measured. This reflects the limited information available on this topic in the literature.

*Vincentian history, mission, and values.* St. Vincent de Paul was a 17th century French priest who cared for thousands of refugees flooding Paris during a civil war resulting in poverty, starvation, and sickness. The Church was also in great need of reform at this time, and St. Vincent de Paul's approach to alleviating poverty shifted from the organization to a personal one. He founded or inspired many organizations still in existence today that carry his vision of service to the sick poor by practicing Christ's teachings. St. Vincent de Paul had a talent for spreading his vision and developing clergy and lay followers to serve in the same spirit. He was named parish priest in Chatillon le Dombes, France, in July 1617 and shortly after, founded his first organization, the Confraternity of Charity, which offered regular care and service to the sick poor.

In 1625, he founded the Priests of the Congregation of the Mission, who ministered to the spiritual needs of the poor and laid the groundwork for what developed into the Daughters of Charity (DOC). Up until this time, sisters were secluded inside

convents, but St. Vincent de Paul broke tradition and sent the sisters into the slums, hospitals, prisons, and battlefields with the message, "Your convent will be the houses of the sick, your cloister the streets of the town, your chapel the parish church." (Truesdall, 2009, p. 6). In this way, the DOC developed the first group of religious sisters to go into the community to teach, nurse, and tend to social problems.

Louise de Marillac and St. Vincent de Paul officially founded the DOC in November 1633. The Daughters provided the physical and spiritual care of the sick poor. Later in 1634, the Ladies of Charity, a confraternity from the Hotel Dieu, a hospital in Paris, was founded and continues to be an international volunteer organization to this day. Nearly two centuries later, Elizabeth Ann Seton founded the Sisters of Charity of St. Joseph in 1809 in Emittsburg, Maryland. The sisters adapted the rules and Vincentian values of the French DOC and later united with the international community based in Paris in 1850 (Daughters of Charity Health System, 2007). This history is important to St. Francis Medical Center because the Vincentian values of respect, compassionate service, simplicity, advocacy for the poor, and inventiveness to infinity are what drive the sisters' mission and the organization to actualize how St. Vincent de Paul would have imparted the Gospel into the world of healthcare today.

The Vincentian values are based on the charity of Christ, who urges those who serve Him to adopt these values. *Respect* is defined as recognizing the value of others. *Compassionate service* is providing excellent care with gentleness and kindness. *Simplicity* is acting with integrity, clarity, and honesty. *Advocacy for the poor* is supporting those who lack resources for a healthy life and full human development. *Inventiveness to infinity* is being continuously resourceful and creative. As the DOC

developed rules for administering their healthcare, i.e., nutrition, medications, dressings, enemas, they were frequently reminded by St. Vincent de Paul and Louise de Marillac in letters to the sisters and in conferences of the need for an attitude of *compassion*, mildness, cordiality, *respect*, and devotion (Sullivan, 1997). Louise de Marillac referred to compassion as a core value in many of her spiritual writings (Sullivan, 1991). She also held *respect for the person* of the patient among the most important attributes. In her writings, she frequently described a *respectful* attitude required of all involved in the healthcare ministry as linked to spiritual roots. She allied *respect* to gentleness even with the most difficult patients who were often seen by others as the outcasts of society. Her message about the manner in which care was delivered in 17th century France is equally fitting today at SFMC, as evidenced by the disadvantaged, underserved individuals who are frequently associated with gangs, are drug dependent, or have a mental illness and are often seen as societal outcasts.

In addition to the professional quality of care required by the sisters, Coste (as cited in Sullivan, 1997) described another rule that St. Vincent de Paul and de Marillac made regarding necessary personal attributes. “They shall carefully practice humility, *simplicity*, and charity, deferring to their companions and to others and performing all their actions from a charitable motive toward the poor and with no concern for the approbation of others” (Coste, as cited in Sullivan 1997, p. 23). St. Vincent de Paul taught the concept of *simplicity* to the Ladies of Charity, by telling them, “dress as *simply* as possible (when visiting the sick) . . . do not cause difficulty to the poor seeing the excesses and extremes of the rich . . . think more of the things they do not have” (Abelly, as cited in Sullivan 1997, p. 24).

*Advocacy* for the poor is rooted in an essential attribute noted by the founders as having the ability to bridge gaps among people and to collaborate with ecclesiastical and civil authorities, the religious, and laity. Sullivan (1997) described this need for collaboration on behalf of the patient as the most innovative aspect of the initial work of the DOC in healthcare. Even in 17th century France, the DOC were called to meet the many challenges and complexities inherent in forging partnerships and alliances designed to ensure quality care for the sick. The continued need for *advocacy* for the poor in Southeastern Los Angeles is a relevant value for the care of the population served by SFMC.

The phrase, "love is inventive to infinity," is attributed to St. Vincent de Paul in Coste's (as cited in Marques, 2005, p. 232) *Biography of a Saint* and refers to being continuously resourceful and creative. The ability to analyze any situation, see potential for improvement, and ultimately identify innovative solutions constitute this value. For example, the necessity to operate an organization effectively based on limited resources demonstrates *inventiveness to infinity*. de Marillac's *inventiveness to infinity* was demonstrated by her creation of a training school in 1642 for the sisters that provided "hands on" experience under her supervision (Sullivan, 1997). Another instance of how these two founders exhibited *inventiveness to infinity* is when they both negotiated with the civil government and administrators for provisions needed to provide their service to the sick poor. They demonstrated a keen ability to get what they needed by contract or in funding to continue their mission. Both were capable of careful financial management, waste elimination, cost containment, and strict recordkeeping of accounts. With the many demands in the current healthcare environment, e.g., third party payers, regulatory

agencies, consumer and advocacy groups, unions, the nursing shortage, this Vincentian value, based on resourcefulness, creativity, and innovation, is critical to balancing patient care and economic needs by clinicians, leaders, and managers. From acquiring funding from private benefactors to influencing and developing public policy that advocates for the poor, *inventiveness to infinity* continues to be a core value in the DCHS.

*Organizational effectiveness related to Vincentian values.* Kouzes and Posner (2003) advocate bringing heart (values), soul, and spirit into the workplace to gain more favorable results in organizations, which should translate into better clinical outcomes and ultimately organizational effectiveness. Both St. Vincent de Paul and de Marillac served as role models and provided both religious and lay leaders with long-lasting examples of values, referred to as the "heart of change." Most significant was their commitment to higher purpose, empowering others within their organizations, and sharing a vision of service to the poor (Posig, 2005). The DOC has a solid virtue based on a "family of faith" notion for those who live and work harmoniously together. Because of the difficult situations the caregiver often experiences in serving the sick, poor, and vulnerable, de Marillac believed that human ties were vital and identified a need to develop a support system (Sullivan, 1997). This demonstrates how personal values and congruence with organizational values calling for mutual respect, forbearance, kindness, gentleness, and forgiveness, which are all attributes of love, might also apply to obtaining better clinical outcomes when caring for patients in trying circumstances.

*Values congruence*. In addition to individual and organizational values research, another area of values research specifically focuses on the degree to which the individual and organizational values are in agreement or are considered to have "values

congruence." Also known as person-organization (P-O) values congruence, this area of study uses either subjective or objective measures (Kristoff, 1996; Posner, 1992; Verqueer, Beehr, & Wagner, 2003). Subjective measures take into account the perception of congruence between the individual and his or her organization, whereby objective measures are conducted by someone within the organization who determines whether congruence exists between the individual and organization. Values congruence refers to the connection between the employee values that influence decisions and behaviors and the organizational values that establish norms that determine codes of conduct, resource allocation, and related considerations (Chatman, 1989; Kristoff, 1996; Rokeach, 1973; Schwartz, 1992). Findings have supported various positive outcomes when there is congruence between personal and organizational values (Amos & Weathington, 2008: Boxx, Odom, & Dunn, 1991; Posner, 1992; Ugboro, 1993).

### *Summary of the Literature Review*

The literature relative to the formation of values and how this process affects human behavior and nursing values in relation to patient care and outcomes, organizational values, and their effect on overall organizational effectiveness and values congruence have been presented above. Historical and landmark studies as well as contemporary research and approaches that have contributed to the body of knowledge most relevant to this study have been included. After a comprehensive review of the literature, no specific evidence has been found regarding nursing values in relation to Vincentian values or how alignment of the two may contribute to organizational effectiveness as defined by patient outcomes in the case hospital. The lack of literature in this area reinforced the need for this study. Additionally, the literature on how personal

values direct behavior, how organizational values contribute to an organization's effectiveness, and the importance of values congruence supports both the need for and the methodology of this study.

# Chapter 3

## Methodology

This research employed a case study design and used a survey method for data collection. The study sought to determine which Vincentian (organizational) values were consistent with those of the Rokeach Values Survey and then establish which of these values were highly aligned with the organization. Through the survey instrument, personal values information was obtained from a self-selected sample of registered nurses (RNs) who possessed current clinical competency. The information was analyzed to determine the degree of congruence with the most highly aligned organizational Vincentian values and the RNs' personal values ratings.

The rationale for a case study design was the need to examine the individual values of nurses relative to those of the organization. It is believed that values can predict behavior and that having nurses perform the desired clinical behaviors associated with caring for patients enhances organizational performance and effectiveness. The intention of this study was not to solve problems, but rather to examine a certain situation, specifically whether individual values were in congruence with the organization's values.

A case study is often used as a method of evaluation to explain situations that need clarity (Yin, 2003). This case study was used to produce information and create knowledge that could influence future leadership strategy and management direction. The nature of the research was exploratory in that the researcher looked for patterns, ideas, or hypotheses rather than testing to confirm already established hypotheses.

Using a survey for data collection provided a numeric description of values of the RN population by studying a sample of that population (Creswell, 2003). An intact

quantitative survey instrument developed by someone other than the researcher provided a measurement of values attributes of the RNs and contextual information about the predominant workforce that cares for patients in the hospital setting during a defined data collection timeframe.

### *Case Setting*

DCHS is a regional healthcare system comprised of five hospitals and medical centers, which spans California from the Bay Area to Los Angeles. The model for care delivery is based on the time-honored values of their sponsors, the Daughters of Charity of St. Vincent de Paul. The system refers to its facilities as local health ministries and demonstrates that healthcare is a ministry, not an industry. DCHS was formed in January 2002. Until 1995, the five California hospitals were part of a national DCHS, now Ascension Health. The Daughters of the Province of the West merged with Catholic Healthcare West after that time in the hope of broadening the Catholic health ministries in California. However, in 2001, the DOC of the West decided to directly sponsor their own health ministry and formed their own organization (Zaccheo & Kerk, 2007).

True to its mission, DCHS held a conference on poverty in 2006 to help focus California's attention on the national poverty crisis. It is estimated that 36 million Americans live in poverty, of which 5 million are in California. At the convention were 500 nationally recognized experts on poverty and community activists, who developed a 6-point plan, with one specific to healthcare—to expand access to healthcare and strengthen Californians' healthcare safety net (Zaccheo & Kerk, 2007). Despite its challenges and the fact that the healthcare system is relatively new, the 2006 annual report's financial summary reflected a $26,607,000 excess of revenues over expenses

(Zaccheo & Kerk, 2007). The 2007 annual report reflected even better revenues over expenses of $46,823,000 (Smith & Zaccheo, 2008). However, in just 1 year, the annual report for 2008 indicated declining financial performance and a deficit of revenues over expenses (-$7,938,000) (Smith & Zaccheo, 2009). According to Robert Issai, President and CEO of DCHS, in his State of the Union Address, this was due rising expenses and declining reimbursement that has not kept pace with inflation in healthcare costs (Issai, 2008).

*St. Francis Medical Center*

The case hospital, one of five California DOC local health ministries, was established in 1945 and is the only comprehensive non-profit Catholic healthcare institution serving southeastern Los Angeles. Its services include a 384-bed acute care hospital, five community-based health clinics, one of the largest and busiest private emergency trauma centers in Los Angeles County, and other educational and community services for the poor. The hospital serves over 700,000 adults and 300,000 children each year. It is a dedicated disproportionate share hospital, with 80% of its reimbursements derived from Medi-Cal and Medicare. In fiscal year 2007, the hospital provided $10,077,000 in care for the sick poor, $7,919,000 in care for the elderly, and gave $8,458,000 in benefits to the broader community (Issai, 2008).

St. Vincent de Paul, the founder of organized charity, continued his ministry into his 70s and spread his mission throughout the world by his writings and inspiration to others. Nearly four centuries have passed and not only are his mission and values still relevant in our society today, but many Vincentian organizations such as St. Francis

Medical Center are as committed to his beliefs as they were in the 1600s—to serve the sick poor. The DCHS mission is as follows:

> In the spirit of St. Vincent de Paul, St. Louise de Marillac, and St. Elizabeth Ann Seton, the Daughters of Charity Health System is committed to serving the sick and the poor. With Jesus Christ as our model, we advance and strengthen the healing mission of the Catholic Church by providing comprehensive, excellent healthcare that is compassionate and attentive to the whole person: body, mind and spirit. We promote healthy families, responsible stewardship of the environment, and a just society through value-based relationships and community-based collaboration. (Daughters of Charity Health System, 2007, para. 4)

*External environment.* As previously mentioned, the closure of a county facility, MLK, has had the most significant economic and social impact on the case hospital in its history. Communities served in the Los Angeles Service Planning Areas (SPA) 6 and 7 are characterized by significant poverty, high unemployment, educational deficiencies, prevalent crime and violence, high teen pregnancy rates, a disproportionate number of undocumented persons, and a high percentage of under- or uninsured families.

*Internal environment*. The organization has experienced significant and rapid change due to the local, state, federal, and societal demands recently put upon it. Profitability is down and the patient population has changed, resulting in the need for increased security measures. Additionally, the intensity of service has risen as demonstrated by sicker patients, which equates to heavier workloads, and employee satisfaction scores were lower in 2006 (the last reporting period) as compared to 2004. The scores under scrutiny were specific to mission and vision typically associated with personal values, a grave concern to DOC. Despite a newly implemented Standards of Behavior initiative in 2007 that re-oriented all employees to live DOC Vincentian values in their day-to-day interactions with patients, visitors, and employees, patient complaints

and union grievances continue to increase. Union problems persist, and the Service Employees International Union organized its service and support workers and had two 1-day strikes in August and October 2008 due to failed negotiations. The union and the hospital have yet to successfully negotiate its expired contract. The organization has been consistent in meeting most of its operational goals and has a healthy, growing foundation, stable executive leadership, and low employee turnover overall.

*Sources of Data*

According to Vogt (2005), "the persons being studied in research in the social and behavioral sciences are often individual persons and may be groups" (p. 333). The source of data in this study was each individual nurse who was considered a single unit of analysis from which data regarding his or her values were gathered. In this study, the participants' values were compared to the Vincentian values of the organization. A second source of data was three content experts who are currently active in the Daughters of Charity Province of the West; these experts provided an understanding of the organization's values. They provided data regarding how specific Rokeach values were consistent (or not) with the organization as well as the extent of the values' alignment with the organization's Vincentian values.

*Data Collection Strategies*

The researcher believes that a survey is the preferred type of data collection procedure for this study based on the following assumptions: (a) ability to identify attributes from a specific population, (b) rapid turnaround in data collection, (c) low cost, (d) convenience, and (e) linear process. Henerson, Morris, and Fitz-Gibbon (1987) stated that self-report measures about attitudes (values) by members of a group are the most

effective means to gather information under the following conditions: (a) when the individuals are able to understand the information gathered from them, (b) when they have sufficient self-awareness to provide the necessary information, and (c) when they are likely to answer honestly and not deliberately falsify their responses. Taking into consideration these notions, the choice of using a survey strategy approach was made on three levels. First, RNs are licensed professionals who hold a minimum of an Associate of Arts degree and carry significant responsibility in the coordination and care of their patients. By possessing these basic qualifications, they demonstrate their ability to receive and gain information from a variety of sources that requires them to interpret and apply information to practice as a part of their jobs. The RNs frequently participate in surveys that solicit their opinions and input about their decision making in the workplace.

Second, RNs at SFMC work in a culture that believes in associates' well being of mind, body, and spirit, as defined by the hospital's sponsors calling on associates' need for self-awareness. Third, the value of low cost and efficiency of results was appealing to the case hospital. The weaknesses of using a survey design include: (a) the use of one strategy, (b) non-cyclical and non-emergent data collection, (c) non-participatory/non-interactive inquiry, and (d) a limited, not broad, view of information.

The Rokeach Values Survey (RVS) was developed by Rokeach (1967). The survey instrument gathered demographic data as well as contained the RVS. The survey instrument was automated on *Survey Monkey* and linked to the hospital intranet for this study, with a dedicated icon for ease of identification and use for the convenience of each participant (Appendix A). It was accessed directly by each of the RN respondents in their assigned work environments or other intranet access site within the hospital.

*Demographics*. The following four demographic characteristics were included in the first section of the survey: (a) religion, (b) ethnicity, (c) age group, and (d) gender. Religion is relevant not only because SFMC is a faith-based organization but, more importantly, it may be meaningful to determine whether there was any one religious group whose results stood out. This research interest is based on the concept that values develop from one's experience in the environment and are influenced by one's family, nation, generation, historical and political events, culture, and religion (Massey, 2008). It is important to look at gender because nursing is a largely female profession and, as such, it is important to evaluate whether males differ in their responses. Over the centuries, philosophers such Immanuel Kant, Otto Weininger, and Friedrich Nietzsche contributed to misogynistic rhetoric often based on gender differences in values.

As recently as two decades ago, researchers were finding dissimilarities in male and female leadership styles characterized by values depicting men as competitive, controlling, and aggressive versus women as cooperative and team-focused (Loden, 1985; Rosener, 1990). O'Fallon and Butterfield (2005) conducted an extensive review on empirical ethical decision making, largely driven by personal values, of 174 business articles published between 1996 and 2003, and evaluated gender differences, finding few significant ones. However, when differences were identified, the females scored higher in ethics compared to men.

## *Instrumentation*

### *Rokeach Value Survey (RVS)*

According to Rokeach (1973), the RVS serves as "an all-purpose instrument for research on human values" (p. 51). This survey tool was developed to assess an

individual's value system, which has an effect on attitudes, social conduct, and the judgment of others. Rokeach theorized that individuals base important judgments and actions on their sense of the relative importance of different values. The survey's design included two distinct values categories: "modes of conduct," which he labeled as *instrumental values,* and "end-states," which he labeled as *terminal values*. Each category is comprised of 18 values, and the participant rank orders both the instrumental and the terminal values in each. The survey was designed to be completed in 10 to 20 minutes. The instrument is comprised of the two types of values sets (Rokeach, 1967).

Terminal values are those that describe an individual's beliefs concerning desirable end-states of existence. Rokeach's terminal values were identified by a consensus process from a review of literature, the researcher's own values, and interviews with individuals. Instrumental values are those that describe an individual's beliefs concerning desirable modes of conduct. These values were derived from Anderson's (1968) research and include only those values that are positive in nature. Rokeach's (1973) terminal and instrumental values are displayed in Table 1.

Table 1

*Rokeach Value Survey: Terminal and Instrumental Values*

| Terminal Values | Instrumental Values |
|---|---|
| Comfortable Life | Ambitious |
| Exciting Life | Broadminded |
| Sense of Accomplishment | Capable |
| World at Peace | Clean |
| World of Beauty | Courageous |
| Equality | Forgiving |
| Family Security | Helpful |
| Freedom | Honest |
| Health | Imaginative |
| Inner Harmony | Independent |
| Mature Love | Intellectual |
| National Security | Logical |
| Pleasure | Loving |
| Salvation | Loyal |
| Self-respect | Obedient |
| Social Recognition | Polite |
| True Friendship | Responsible |
| Wisdom | Self-controlled |

Brookhart (1992) noted that using this type of ranking, which involves ipsative measures, can lead to difficulty in the data analysis. However, Cohen (1982) noted that many studies have used the RVS and the infirmity of the ipsative measures is successfully overcome by the typically large sample sizes, thus producing statistically significant results. Kitwood (1982) also identified the instrument's weakness in terms of Rokeach's basic assumption that all participants have a personal value system in which there is a strict rank ordering of the value elements. Despite these weaknesses, the RVS is

more directly concerned with values as philosophically understood and is still better than most, if not all, other available instruments (Kitwood, 1982)

*Validity*. Construct validity of the RVS relative to Rokeach's theories of values in relationship to the quality of life, attitudes, and political and social behavior, and cognitive change has been studied extensively (Rokeach, 1973). The rankings of values were examined for validity by contrasting groups, defined by gender, income, education, ethnicity, age, and religious preference. Terminal values differences by gender = 12/18, income = 9/18, and education = 14/18. Instrumental values' differences by gender = 8/18, income = 11/18, and education = 11/18. Its reliability, construct validity, and extensive norms make the RVS a useful research instrument in an early stage of value theory development (Cohen, 1982).

*Reliability*. Over the past 30 years, the RVS has exhibited adequate test-retest reliability estimates. The test-retest method is fairly outdated but was a common measure of reliability in the 1970s and 1980s. Spearman rho estimates ranged from .51 to .88, with a median of .65 for terminal values. Instrumental values ranged from .45 to .70, with a median of .61 (Sanford, 1995). Brookhart (1992) stated that the reliabilities were acceptable under two conditions: (a) the data are used for research with groups, not individuals; and (b) the data are used with college students or others who have verbal abstraction ability. Both of these conditions exist in this case study.

Gibbins and Walker (2001) tested the 36 RVS values for intercorrelations, with the assumption that each value assessed may be interpreted differently or have multiple meanings. This was based on the belief that people of different religious, social, and political persuasions may have different understandings of the values and therefore

ranking of a values system would not be valid. A factor analysis was conducted on the combined values and seven factors. All but one value had more than one significant factor or dimension of meaning, and two major factors accounted for 41% of the variance in value rankings. Gibbins and Walker concluded that these results indicate that the RVS is not a good measure of the relative desirability of different values, and they believe that individuals' evaluations of the world may be based on more fundamental values than those identified in the RVS.

Although Gibbins and Walker (2001) tried to take into consideration the different ways that people from other cultures may interpret the values, their sample was from a different culture (Australia), and this may have not been given enough consideration in their study. It may be unrealistic to believe that one could develop a values survey that does not have varying interpretations by its respondents. The very nature of values is subjective, and it must be noted that values develop and are influenced by experiences and political, social, and historic events that are specific to individuals, often with high degrees of variability. Rokeach's research was based on the assumption that there is a comparative nature to values and consequently ranking values is meaningful. However, the RVS is based on American values, and the difference between Australian and American values may be significant enough to render Gibbins and Walker's results inconclusive. The universality of the RVS values has not been determined. The reliability of the RVS was assessed and is reported in the following chapter.

*Tool structure, adaptation, and scoring.* The RVS requires the participant to rank order each of the 18 terminal values from most important to least important, followed by the rank ordering of the 18 instrumental values. The value of most importance appears in

box 1 and least importance appears in box 18. Ranking is consistent with Rokeach's theory about the comparative nature of values. The tool was designed to use gummed labels that peel off, and the participant matches the gummed labels to the rankings on the survey sheet. The researcher was granted permission by the publisher via email, however, to convert the manual tool to an electronic version.

By utilizing *Survey Monkey*, the tool was automated to perform the same function of matching each value to a ranking. All values on the electronic survey were positively stated as is the case in the manual version. The values were arranged in alphabetical order and were accompanied by a short description. When rankings of both sets of values are complete, the results are meant to represent a comprehensive view of what is most important in the participant's life. There is no cumulative scoring involved but rather a rank order of each of the values.

The electronic version of the RVS was piloted with a small sample of nurses who represented the targeted population. These individuals did not have difficulty completing the survey in its entirety, nor did they indicate any concerns regarding the relatively lengthy ranking procedure. This was not the case, however, for the study's sample at large. The automation and conversion of this tool to an electronic version did have an apparent impact on its usability, as a large majority of the targeted sample was not able to complete the survey rankings as needed. This created a major limitation in this study, as the sample size was significantly reduced.

*Expert Panel Determination of Rokeach Values Consistency*

Prior to data collection, an expert panel of three DOC sisters was formed to determine whether there was consistency between the Vincentian values of the

organization and the 36 Rokeach values in the RVS. There are five Vincentian values in the SFMC Standards of Behavior listed in the following order: (a) respect, (b) compassionate service, (c) simplicity, (d) advocacy for the poor, and (e) inventiveness to infinity (Brown, 2006). Understanding the importance of the organizational values (Vincentian) and whether they are consistent with the RVS, specifically terminal and instrumental values, was a necessary step before conclusions could be made to determine congruence.

To establish which RVS values were consistent with the five Vincentian values, the researcher asked each sister on the panel to provide content expertise. Each of the three content experts is a practicing sister in the DOC and has responsibility for upholding its mission and overseeing integration in its local health ministries. To make this determination of consistency, the researcher developed a "congruence grid," with the values from both the terminal and instrumental value classifications listed on the y-axis and the five Vincentian values listed on the x-axis (Appendix B). The congruence grid was then emailed to the three experts for their completion.

The instructions asked them to mark an "x" in the box of the corresponding Vincentian value(s) with each of the terminal or instrumental values listed on the y axis. It was possible that a terminal or instrumental value was not consistent with any of the five Vincentian values, in which case they would mark the box entitled "N/A" for "not applicable." A unanimous decision of the experts was required for each of the values in determining whether there was consistency between the RVS value and one of the Vincentian values. This process yielded the list of Rokeach Values considered consistent with the organization's values.

*Determination of Organizational Value Alignment*

After the sister's determination of consistency was made, a further assessment of the resultant two value sets was conducted to establish the degree to which each value was aligned with SFMC. Each of the three expert sisters independently rated each value as highly aligned, moderately aligned, or somewhat aligned with the organization's values. The extent of alignment of each value would be determined if two of the three experts agreed. This rating enabled the researcher to determine a level of congruence between individual nurse values and those of the organization. This was done by both examining the values ranked as most important (lowest mean ranking) and least important (highest mean ranking) and applying the results from the sisters' assessment of alignment. High, moderate, and low levels of congruence were then possible.

## *Data Collection Procedures*

In the pre-survey phase, two methods of communication were employed to inform the RNs of the pending survey period. The first was a letter that concisely described the aim of the survey and how the nurses were invited to participate. The letter of introduction was sent to each perspective RN participant and requested his or her completion of the survey (Appendix C). The second strategy was to hang a colorful 11" x 17" poster with information regarding the survey in each workplace communication board located in each of the departments.

Survey completion was scheduled during a 2-week survey period, November 3-17, 2008, that was publicized throughout the medical center. The data occurred only during that time period, i.e., 2 calendar weeks, 24 hours a day, 7 days per week. This was believed to be sufficient time and was intended to maximize the number of survey

participants by accommodating RNs' alternating bi-weekly work schedules as well as to capture those who often work evening/night hours or weekends.

The case hospital employs approximately 700 RNs who served as the target population. All full-time and part-time RNs employed by SFMC were sent a survey notification by the human resources department and had the opportunity to participate in the study. Per diem, traveler, and contracted registry RNs were excluded from the study because they are temporary personnel and may not have had the same commitment and organizational knowledge as did the associates who have had the benefit of a full orientation and experience at the hospital.

The sample for the study included those clinical RN associates who accessed the hospital intranet for completion of the survey within the targeted study period; therefore, sample size was not predetermined. The researcher anticipated that those RNs who provided care to patients during the study period were most likely to participate due to the limited access to the hospital intranet of those RNs not scheduled to work during that timeframe, as access requires the RN to be at the site.

*Human Subjects' Considerations*

An inquiry was made to the Institutional Review Board (IRB) at SFMC regarding their committee requirements and approval process. It was determined by the Chairman of the SFMC IRB that, according to organizational policy, because this study was non-clinical, it did not require IRB approval (Appendix D). The role of the IRB committee of the medical staff is to review and approve clinical research conducted in inpatient, outpatient, and ambulatory treatment settings (Miller, 1997). The policy and procedure clearly states, "The IRB is required to review all research and clinical investigations that

will be conducted at SFMC involving patients and/or information from the patient's record" (Miller, 1997, p. 1). This study did not meet either criteria involving patients or medical records.

Approval to conduct the study was requested through the Graduate and Professional Schools Institutional Review Board (GPS-IRB) at Pepperdine University per the protocol. The GPS-IRB serves under the authority of the U.S. Department of Health Services and is housed in the Office of Human Research Protection. The IRB was established to protect the rights and welfare of human research participants. Permission was granted by the GPS-IRB for expedited review, and waiver of the documentation of consent was approved (Appendix E).

One potential risk that was identified was due to the researcher's role within the case hospital as Vice President of Patient Care Services. At times, the targeted population may feel coerced when they are under the supervision or control of the researcher. It may be difficult for the perspective participant to refuse an invitation to participate in the study (Locke et al., 2000). For this reason, the researcher solicited participation using a generic letter to prospective participants and posted information about the survey (Appendix F) in RN employee work areas to minimize such a risk. As part of the procedure, an electronic informed consent was utilized, explaining the intent of the research and the rights of the participants (Appendix G). The informed consent addressed the fact that participation was strictly voluntary and that the participants could choose not to participate at any time without penalty. The participants were also informed that the surveys were anonymous; therefore, standards of confidentiality were adhered to. The

researcher also provided confidentiality by maintaining security of all data in a secured personal computer, complete with a secured username, password, and access code.

### *Analytical Techniques*

The sample of nurses who chose to participate was reported as a percentage of the targeted population. Demographics of those participating were reported using frequency distributions. The expert panel ratings for consistency and alignment were determined based on a unanimous decision by the three experts. The participants' value rankings were analyzed using descriptive analyses of data, including frequency distribution, percentages, and means. Ranked values were averaged for the sample and arranged in an array from the lowest mean value ranking (indicating the most important value) to the highest mean value ranking (indicating the least important value).

### *Assumptions and Limitations*

Several assumptions were made in regard to this study. The first assumption was that RNs were a reliable source of information to determine individual values. The second assumption was that RNs understood the importance of the mission and organizational Vincentian values and had some sense of self-awareness in their patient care role at SFMC. The third was that RNs were familiar with survey participation at the hospital and historically contributed to ensure a sufficient sample size. The fourth assumption was that converting the RVS instrument to an electronic format would not affect the survey's usability as a rank-ordering tool.

This study was based on a single organization and, therefore, findings cannot be generalized to other Catholic hospitals, despite their comparability. The values that emerged from this study, along with the findings, serve as the basis for replication or

adaptation of this study in other healthcare institutions in the DCHS or other Catholic or faith-based hospitals. The case study design was used to assess individual nursing values congruence with the organizational values of the case hospital in the hope that identifying any incongruence could result in interventions that could lead to improved patient care. Chapter 4 presents the findings of this analysis.

# Chapter 4

## Results

The primary purpose of this research was to determine whether there was congruence between the personal values of RNs and the organizational Vincentian values of the hospital presented in this case study. When individual values and organizational values are aligned, performance outcomes are maximized (Blanchard & O'Connor, 1997; Covey, 2003; U.S. Department of Health and Human Services, 2007). The collection of data occurred during the nurses' everyday practice or, as Yin (2004) described, "investigating real-life events in their natural settings" (p. xii). This is particularly useful when the phenomenon and context are not readily separable. The specific methods employed to conduct this study were presented in Chapter 3. This chapter presents the results of the data analysis and is organized into four main sections: (a) description of the sample, (b) value rankings, (c) organizational values, and (d) congruence between the RNs' and the organization's values.

### *Description of the Sample*

There was significant difficulty in the data collection procedure. The target population was 731 RNs, but only 105 (14%) participated. Additionally, most of the 105 surveys were unusable due to either missing data or data that was not recorded according to the instructions, e.g., more than one value was ranked as first or there was no ranking of values. Of the 105 completed surveys, only 27 had appropriately ranked values. This sample of 27 nurses represented 4% of the targeted population and 26% of the nurses who had attempted to participate. Despite the unanticipated reduction in sample size, a

thorough item data analysis of the 36 Rokeach values was completed and compared, as planned, to the five Vincentian values of the organization.

*Demographics*

The four demographic characteristics requested in the survey were religion, ethnicity, age group, and gender. Each is presented below as a means to describe the sample and subgroups that were used for the analysis of value rankings.

*Religion*. Of the 27 respondents, 19 (70%) were Catholic and 8 (30%) were non-Catholic. A majority of Catholic respondents was expected because the organization is Catholic. The human resources department does not maintain demographic statistics on the religious preferences of its associates, so the researcher was unable to compare this finding to the greater RN population.

*Ethnicity*. The sample's distribution is close to the overall RN population, as reported by the human resources department as of December 31, 2008, with the three most predominant ethnic groups being Asian, Hispanic/Latino, and African American. Asian representation in the sample was 37% versus the SFMC statistic of 46%, the Hispanic/Latino sample was 30% versus 21%, and the African American sample was 19% versus 22%. Caucasian RNs were 4% of the sample versus 11% of the SMC population. Both the Asian and Hispanic/Latino samples differed the most, by 9% from the SFMC population.

In regard to Hispanic/Latino nurses, who in this study represented 30% of the sample, the National Sample Survey of Registered Nurses (NSSRN), a study completed every 4 years by the Bureau of Health Professions of the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), found that,

nationally, Hispanic/Latino nurses account 10.7%. Although in the national data, this category grew by 35% from 1996 to 2000, the number of Caucasian RNs remains close to seven times larger than the number of Hispanic/Latino RNs. Hispanic/Latino RNs remain the most underrepresented ethnic group in nursing when compared with the 14.1% Hispanic/Latino population in the U.S. (Health Resources and Services Administration, 2004). Putting these statistics in a different context, the Los Angeles Hispanic/Latino population is 48% (U.S. Census Bureau, 2007). Therefore, the 30% in this sample is an underrepresentation for the case hospital's location. These data are presented in Table 2.

Table 2

*Distribution by Ethnicity*

| Ethnicity | Sample (*N* = 27) | % | Targeted Population (*N* = 731) | % |
|---|---|---|---|---|
| Asian | 10 | 37 % | 333 | 46% |
| Hispanic | 8 | 30 % | 152 | 21% |
| African American | 5 | 19 % | 163 | 22% |
| Pacific Islander | 3 | 11 % | 2 | 0.2% |
| European | 1 | 3% | 81 | 11% |

*Age groups.* The majority of the RNs (*n* = 24) in the sample were between the ages of 30 and 59. The findings are fairly consistent with the NSSRN conducted in 2004. The mean age of the U.S. RN population continues to rise and increased to 46.8 years of age compared to 45.2 years in 2000 and 44.3 years in 1996 (Health Resources and Services Administration, 2004). At SFMC, the largest category in the sample was between the ages of 40 and 49 (33%), followed by ages 50 to 59 (30%), and 30 to 39

(26%), as seen in Figure 2. The dominant age group of 40 to 49 is consistent with the NSSRN national average of 46.8 years. The most significant difference between the SFMC sample and the NSSRN data is seen in the SFMC sample, in which 9 (33%) of the RNs were under the age of 40 versus 26.3% in the national sample.

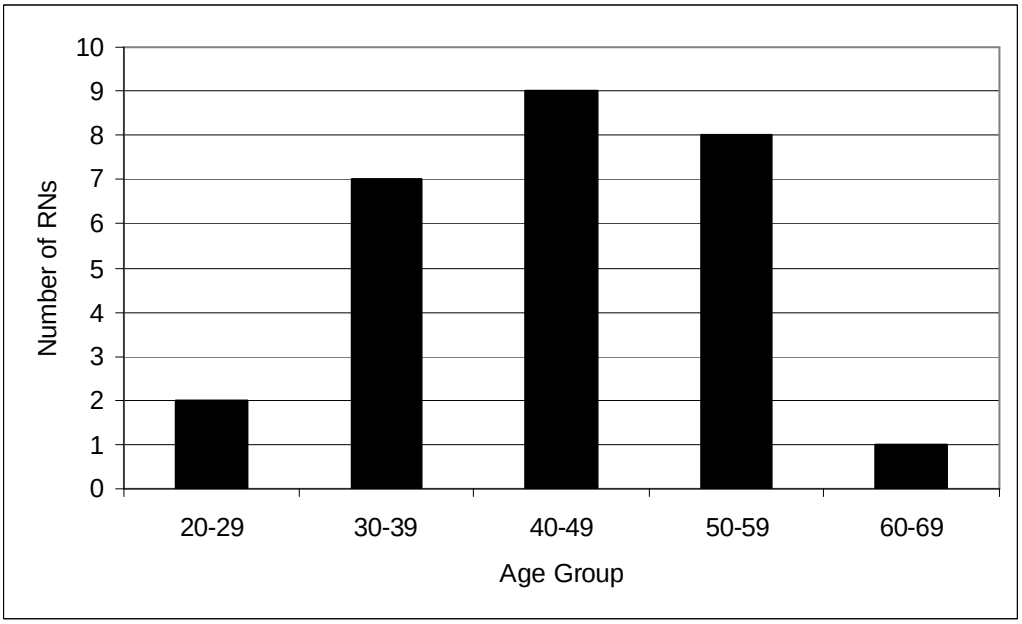


*Figure 2.* Sample distribution of RNs by age group of participant (*N* = 27).

Comparing the sample with the SFMC statistics, for those 30 years and under, the results indicated that 7% were in the 20-29 age group versus 4% for the SFMC data. It should be noted that the SFMC data are aggregated differently from the sample data. At SFMC, 80% of the RNs are between 31 and 55 years old versus 89% of the sample RNs in the age groups that span 30 to 59.

*Gender.* The sample of 27 RNs was comprised of 19 females (70%) and 8 males (30%). There were a much higher percentage of male respondents compared to national statistics. According to the most recently published HRSA report on RNs, only 5.8% are male (Health Resources and Services Administration, 2004). At SFMC, there is a higher

percentage of males, as compared to the sample, at 13%. There was a 14.5% increase between 2000 and 2004 in the number of male RNs nationwide (U.S. Census Bureau, 2007). Nevertheless, it is still noteworthy that 30% of the sample was male.

### *Value Rankings*

Value rankings for the sample are reported in the two categories of the RVS: terminal and instrumental values. Ranked values were averaged for the sample and arranged from the lowest mean value ranking (indicating the most important value) to the highest mean value ranking (indicating least important value). Values ranked most important and least important are presented, including the percentage of the sample contributing to the average ranked value. Also reported are the terminal and instrumental values that are consistent with the organization's Vincentian values, as based on the review by the expert panel of DOC sisters.

#### *Terminal Values*

Of the 18 terminal values in the RVS, 3 emerged with the lowest mean rankings, reflective of the most important values in the set. In the order of most important, health had the lowest mean ranking of 4.11, with 85% of the respondents ranking health within their top five. The second value ranked as most important, family security ($M$ = 4.41), was selected as part of the top five values by 74% of the sample. The third value considered most important was salvation ($M$ = 6.33), with 56% of the participants ranking this value within their top five. The remaining 15 terminal values were ranked within the top five most important values by 7-37% of the sample (Table 3).

Table 3

*Mean Ranking Scores for Terminal Values (N = 27)*

| Terminal Value | *M* | *n* | % |
|---|---|---|---|
| Health | 4.11 | 23 | 85% |
| Family Security | 4.41 | 20 | 74% |
| Salvation | 6.33 | 15 | 56% |
| Freedom | 7.44 | 10 | 37% |
| Inner Harmony | 7.78 | 9 | 33% |
| Self-respect | 7.81 | 8 | 30% |
| Mature Love | 8.37 | 7 | 26% |
| Equality | 8.78 | 9 | 33% |
| Comfortable Life | 9.15 | 7 | 26% |
| Sense of Accomplishment | 9.74 | 6 | 22% |
| National Security | 10.15 | 4 | 15% |
| True Friendship | 10.30 | 2 | 7% |
| Wisdom | 10.85 | 4 | 15% |
| Pleasure | 11.07 | 3 | 11% |
| Exciting Life | 11.26 | 4 | 15% |
| Social Recognition | 12.48 | 1 | 4% |
| World at Peace | 12.67 | 4 | 15% |
| World of Beauty | 15.33 | 2 | 7% |

The three terminal values with the highest mean rankings considered “least important” in the sample were world of beauty (*M* = 15.33), world at peace (*M* = 12.67), and social recognition (*M* = 12.48). World of beauty had the highest mean score of 15.33 and thus was considered the least important value for the sample and a low frequency distribution (7%), ranking this value in the top five.

*Instrumental Values*

Of the 18 instrumental values, the following 3 had the lowest mean scores and are listed in the order of importance: honest (*M* = 4.67), responsible (*M* = 6.96), and capable (*M* = 7.11). A majority of the RN sample (59%) ranked honest in the top five of their instrumental values. The second instrumental value ranked as most important, responsible (*M* = 6.96), was in the top five values of 44% of the sample. The third instrumental value, capable (*M* = 7.11), was ranked most important by 37% of the sample. The remaining 15 instrumental values were ranked within the top five by 7-37% of the sample.

The three instrumental values with the highest mean rankings, considered "least important" in the sample, were imaginative (*M* = 12.68), self-controlled (*M* = 11.81), and clean (*M* = 11.52). Imaginative had the highest mean score of 12.68, making it the least important value of the sample and a low frequency distribution (7%), ranking this value in the top five (Table 4).

Table 4

*Mean Ranking Scores for Instrumental Values (N = 27)*

| Instrumental Value | *M* | *n* | % |
|---|---|---|---|
| Honest | 4.67 | 16 | 59% |
| Responsible | 6.96 | 12 | 44% |
| Capable | 7.11 | 10 | 37% |
| Independent | 8.52 | 8 | 30% |
| Intellectual | 8.93 | 7 | 26% |
| Helpful | 8.96 | 7 | 26% |
| Ambitious | 9.26 | 10 | 37% |
| Broadminded | 9.33 | 8 | 30% |
| Courageous | 9.37 | 9 | 33% |
| Polite | 9.63 | 6 | 22% |
| Loyal | 9.85 | 9 | 33% |
| Obedient | 10.11 | 8 | 30% |
| Loving | 10.15 | 6 | 22% |
| Forgiving | 11.00 | 2 | 7% |
| Logical | 11.07 | 2 | 7% |
| Clean | 11.52 | 7 | 26% |
| Self-controlled | 11.81 | 5 | 19% |
| Imaginative | 12.68 | 2 | 7% |

*Value Rankings by Demographic Subgroups*

The value rankings, also analyzed by the demographic subgroups of religion, ethnicity, age, and gender data, are reflective of the value rankings of each subgroup. Despite the subgroups' small size, much of the data is consistent with the findings for larger sample of 27.

*Religion.* The large number of Catholic nurses (*n* = 19, 70%) in the sample is expected in a Catholic hospital. A distribution of terminal values by mean ratings of Catholic and non-Catholic RNs is displayed in Table 5.

Table 5

*Mean Ratings of Terminal Values by Religion of Participant (N = 27)*

| | *M* | |
|---|---|---|
| Terminal Value | Catholic (*n* = 19) | Non-Catholic (*n* = 8) |
| Comfortable Life | 8.58 | 10.50 |
| Equality | 8.74 | 8.88 |
| Exciting | 10.79 | 12.38 |
| Family Security | 4.05* | 5.25* |
| Freedom | 7.47* | 7.38* |
| Health | 3.47* | 5.63* |
| Inner Harmony | 7.53 | 8.38 |
| Mature Love | 8.11 | 9.00 |
| National Security | 10.00 | 10.50 |
| Pleasure | 11.42 | 10.25 |
| Salvation | 6.68* | 5.50* |
| Self-respect | 7.89 | 7.63 |
| Sense of Accomplishment | 10.42 | 8.13 |
| Social Recognition | 13.00** | 11.13** |
| True Friendship | 10.79 | 9.13 |
| Wisdom | 10.95 | 10.63 |
| World at Peace | 12.11** | 14.00** |
| World of Beauty | 15.84** | 13.88** |

*Note.* * = Most important, ** = Least important.

The four top terminal values (lowest mean ratings) of Catholic and non-Catholic RN were consistent with the most important terminal values of the overall sample. In order of importance, the Catholic respondents identified health as their most important

terminal value (*M* = 3.47), followed by family security (*M* = 4.05), salvation (*M* = 6.68), and freedom (*M* = 7.47). The non-Catholic subgroup selected the same four terminal values as most important in slightly different order. Family security (*M* = 5.25) was ranked most important, with salvation (*M* = 5.50) as the second most important, followed by health (*M* = 5.63), and freedom (*M* = 7.38).

Three out of four terminal values with the highest mean ratings were ranked as least important by both Catholic and non-Catholic RNs. The Catholic group identified world of beauty (*M* = 15.84) as the least important of the terminal values. This is consistent with the overall sample. The next least important by Catholic RNs was social recognition (*M* = 13.0), followed by world at peace (*M* = 12.11) and pleasure (*M* = 11.42). The non-Catholic RNs ranked world at peace (*M* = 14.0) as the least important, followed by world of beauty (*M* = 13.88), exciting life (*M* = 12.38), and social recognition (*M* = 11.13). The biggest variation in comparing Catholic (*M* = 10.79) to non-Catholic RNs (*M* = 12.38) is exciting life. All five of the least important terminal values of both Catholics and non-Catholics are consistent with the overall sample's least important values.

The three top instrumental values (lowest mean ratings) endorsed by Catholic and non-Catholic RNs were consistent with the four most important instrumental values of the overall sample. A distribution of instrumental values by mean ratings of Catholic and non-Catholic RNs is presented in Table 6.

Table 6

*Mean Ratings of Instrumental Values by Religion of Participant (N = 27)*

| | *M* | |
|---|---|---|
| Instrumental Value | Catholic (*n* = 19) | Non-Catholic (*n* = 8) |
| Ambitious | 9.68 | 8.25 |
| Broadminded | 9.32 | 9.38 |
| Capable | 7.84* | 5.38* |
| Clean | 13.00** | 8.00 |
| Courageous | 9.05 | 10.13 |
| Forgiving | 9.63 | 12.88** |
| Helpful | 8.74 | 9.50 |
| Honest | 3.58* | 7.25* |
| Imaginative | 13.26** | 9.25 |
| Independent | 9.26 | 6.75 |
| Intellectual | 9.11 | 8.50 |
| Logical | 11.53 | 10.00 |
| Loving | 8.95 | 13.00** |
| Loyal | 9.11 | 11.63** |
| Obedient | 9.63 | 11.25 |
| Polite | 9.21 | 10.63 |
| Responsible | 6.37 | 8.38 |
| Self-controlled | 12.21** | 10.88 |

*Note.* * = Most important, ** = Least important.

In order of importance, the Catholic respondents identified honest as their most important instrumental value (*M* = 3.58), followed by responsible (*M* = 6.37) and capable (*M* = 7.84). The non-Catholic subgroup selected two of the three instrumental values selected by Catholic RNs as most important but in a slightly different order. The non-Catholic group selected capable (*M* = 5.38) as most important, with independent (*M* = 6.75) as the second most important, followed by honest (*M* = 7.25).

The instrumental values with the highest mean ratings indicate some small differences when comparing the Catholic and non-Catholic groups. The Catholic RN subgroup is most consistent with the overall sample, with the same four instrumental values being consistent but ordered slightly differently. Imaginative ($M$ = 13.26) ranked least important by the Catholic RNs compared to the non-Catholic RNs ($M$ = 9.25). The Catholic group also identified clean ($M$ = 13.0) as the second least important of the instrumental values, followed by self-controlled ($M$ = 12.21). Both of these findings are consistent with the overall sample's highest three mean scores (least important). The non-Catholic RNs ranked loving ($M$ = 13.0) as the least important, followed by forgiving ($M$ = 12.88), and loyal ($M$ = 11.63). One variation is noted when comparing Catholic to non-Catholic RNs; for loyal, Catholic RNs rated the value with a mean of 9.11.

The vast majority of the religious demographic subgroups of Catholic and non-Catholic were consistent with the values distribution in the larger sample. Both the Catholic and non-Catholic subgroup findings included the same most important terminal values in their top four and the same three values chosen as least important. The same is true for the top two most important for instrumental values. However, the non-Catholic RNs' instrumental values rated as least important were slightly different; they chose logical, loving, and forgiving in contrast to the two least important ranked by both the sample and the Catholic RNs, which were imaginative and self-controlled.

*Ethnicity.* The data from the three largest ethnic groups of the sample, Asian ($n$ = 10), Hispanic/Latino ($n$ = 8), and African American ($n$ = 5), were analyzed. These three ethnicities are representative of 85% of the sample. Low and high mean value ratings were determined for both terminal and instrumental values. In all three ethnic groups,

health was among the three lowest mean ranked values, signifying high importance in the terminal category, with a mean ranking as follows: Asian (*M* = 3.40), Hispanic/Latino (*M* = 5.13), and African American (*M* = 4.80). This is consistent with the full sample's most important value of health. Table 7 presents the mean ratings for terminal values.

Table 7

*Mean Ratings of Terminal Values by Ethnicity of Participant (N = 23)*

| | *M* | | |
|---|---|---|---|
| Terminal Value | Asian (*n* = 10) | Hispanic (*n* = 8) | African American (*n* = 5) |
| Comfortable Life | 8.30 | 8.63 | 11.20 |
| Equality | 9.30 | 8.88 | 7.20 |
| Exciting Life | 10.00 | 10.13 | 13.20** |
| Family Security | 4.50* | 6.63* | 2.40* |
| Freedom | 8.30 | 7.63 | 3.40* |
| Health | 3.40* | 5.13* | 4.80* |
| Inner Harmony | 7.00 | 8.63 | 8.60 |
| Mature Love | 7.10 | 7.38 | 10.80 |
| National Security | 8.30 | 13.00** | 10.20 |
| Pleasure | 11.50 | 8.88 | 12.40 |
| Salvation | 7.20 | 8.25 | 5.60 |
| Self-respect | 6.80* | 8.25 | 7.40 |
| Sense of Accomplishment | 9.60 | 7.88 | 6.50 |
| Social Recognition | 11.70 | 11.13** | 14.00** |
| True Friendship | 12.20 | 8.50 | 9.00 |
| Wisdom | 13.20** | 9.50 | 10.40 |
| World at Peace | 13.00** | 4.25 | 11.80 |
| World of Beauty | 15.80** | 15.00** | 15.80** |

*Note.* * = Most important, ** = Least important.

The first two terminal values (lowest mean ranking) in the Asian subgroup were consistent with those of the overall sample: health (*M* = 3.40) and family security (*M* =

4.5). The least important values in the Asian subgroup were world of beauty (*M* = 15.80), followed by wisdom (*M* = 13.20) and world at peace (*M* = 13.0). Two of these three terminal values, with the exception of wisdom, are consistent with the least important of the entire sample.

The two most important Asian instrumental values are honest (*M* = 4.20) and responsible (*M* = 5.20). This ordering is the same as that of the overall sample. In two out of three of the least important instrumental values, the Asian RNs ranked the least important values as imaginative (*M* = 12.7), courageous (*M* = 11.6), and clean (*M* = 11.6). Imaginative and clean are among the highest mean rankings in the sample. The mean rankings of the instrumental values for all three ethnic groups are presented in Table 8.

Table 8

*Mean Ratings of Instrumental Values by Ethnicity of Participant (N = 23)*

| | *M* | | |
|---|---|---|---|
| Instrumental Value | Asian (*n* = 10) | Hispanic (*n* = 8) | African American (*n* = 5) |
| Ambitious | 10.90 | 5.63* | 9.20 |
| Broadminded | 7.50 | 9.38 | 10.40 |
| Capable | 9.40 | 6.13 | 5.00* |
| Clean | 11.60** | 12.25 | 9.00 |
| Courageous | 11.60** | 6.00* | 8.80 |
| Forgiving | 11.40 | 9.25 | 12.40** |
| Helpful | 11.10 | 5.50 | 9.20 |
| Honest | 4.20* | 7.88* | 4.20* |
| Imaginative | 12.70** | 13.63** | 13.80** |
| Independent | 8.60 | 7.75 | 9.20 |
| Intellectual | 9.40 | 7.38 | 7.60**** |
| Logical | 11.20 | 11.38 | 11.00 |
| Loving | 10.00 | 10.00 | 11.80** |
| Loyal | 10.70 | 8.50 | 11.00 |
| Obedient | 8.40 | 13.38** | 9.00 |
| Polite | 7.00* | 12.75 | 10.20 |
| Responsible | 5.20* | 8.50 | 7.60 |
| Self-controlled | 9.50 | 15.63** | 10.20 |

*Note.* * = Most important, ** = Least important.

Hispanic/Latino RNs, at 30%, were the second largest ethnic group in the sample. The distribution of mean rankings of terminal values for this group is presented above in Table 7. The lowest ranked terminal value of this group is different from that of the other subgroups and the overall sample. World at peace was the most important (the lowest ranked) (*M* = 4.25). The next two most important terminal values of health (*M* = 5.13)

and family security (*M* = 6.63) are consistent with the top three terminal values in the overall sample. The least important terminal values, in descending order of mean ranking, are world of beauty (*M* = 15.0), national security (*M* = 13.0), and social recognition (*M* = 11.13). Two of the three least important terminal values are consistent with the least important terminal values ranked in the overall sample, with national security as the exception.

The most important Hispanic/Latino instrumental values (lowest mean rated scores) are honest (*M* = 5.50), followed by ambitious (*M* = 5.63) and courageous (*M* = 6.0). Only honest is consistent with the most important instrumental values of the overall sample. The least important (highest mean ranks) in this category, in descending order, are self-controlled (*M* = 15.63), imaginative (*M* = 13.63), and obedient (*M* = 13.38). Two of the three are also ranked this way in the overall sample, except for obedient, with an overall mean rank of 10.11 (Table 8).

African American RNS comprised 19% of the sample, and their mean rankings of terminal values are presented in Table 7 above. Four of the most important values (lowest mean scores) are family security (*M* = 2.4) as most important, followed by freedom (*M* = 3.4), health (*M* = 4.8), and salvation (*M* = 5.6). All four are consistent with the overall sample's top four terminal values. The African American RNs' least important terminal values (highest mean scores) were world of beauty (*M* = 15.8), followed by social recognition (*M* = 14.0), and exciting life (*M* = 13.2). These three are consistent with the four least important terminal values of the overall sample.

Honest (*M* = 4.2) and capable (*M* = 5.0) received the lowest mean ratings of the instrumental values by the African American RNs. These two are within the top three

most important instrumental values in the overall sample. The two least important instrumental values in this group are imaginative (*M* = 13.80) and forgiving (*M* = 12.40). Imaginative is also the least important instrumental value of the overall sample (Table 8).

For all the ethnic groups, world of beauty was the least important (highest ranked) terminal value, with a range of mean scores of 15.0 to 15.8, as well as the least important value in the overall sample of 27. Of the terminal values, there were small differences noted among the ethnic subgroups and the sample. Among them, the Asian subgroup rated self-respect as the third most important value, compared to the sample and other ethnic subgroups, who rated it fifth or sixth. The Hispanic/Latino RNs ranked the terminal value, world at peace (*M* = 4.25), as having the most importance; however, it was ranked lowest by both the overall sample and the other two ethnic groups with ratings at the second, third, and fourth least important value of the entire terminal set.

The African American RNs ranked freedom as their second most important terminal value, compared to the entire sample and other ethnic groups. This is significant because African Americans have struggled for their freedom within their lifetime. Of the least important terminal values of the ethnic groups, there were minor variations. The Hispanic/Latino RN's second least important value was national security (*M* = 13.0), which was different than that of both the entire sample and the other two ethnic groups. In this group, the most important ranked value was world at peace. Finally, the African American RNs rated exciting life as the third least important, which is different from both the entire sample and the other two ethnic groups.

In the instrumental value category, all three largest ethnic groups ranked honest as the highest value in importance, with mean scores ranging from 4.2 to 5.5, and it was

also the most important value in the overall sample of 27. Two of the three largest ethnic groups selected imaginative as the instrumental value with the least importance, with scores ranging from 12.7 to 13.8, and this value had the lowest ranking (highest mean score) in the overall sample (12.68).

In the instrumental category, the Asian group rated polite ($M$ = 7.0) as third most important value, which was different from the rankings of both the entire sample and the other two ethnic groups. In the Hispanic/Latino group, helpful ($M$ = 5.50) and ambitious ($M$ = 5.63) were the two most important values, which stood in contrast to the rankings of the entire sample and the other two ethnic groups. In the African American group, intellectual was the third most important value, which again was different from the rankings of the entire sample and other two ethnic groups. Imaginative was consistently within the first or second least important instrumental values in the sample and all three ethnic subgroups.

*Age groups.* The sample of 27 was broken down into 5 age groups: 20-29 ($n$ = 2), 30-39 ($n$ = 7), 40-49 ($n$ = 9), 50-59 ($n$ = 8), and 60+ ($n$ = 1). Due to the low numbers in both the 20-29 ($n$ = 2) and 60+ ($n$ = 1) groups, any analysis would be insignificant. Thus, these two groups were eliminated from the analyses. The majority (89%) of the sample was between the ages of 30 and 59. The mean ratings of terminal values by age group are shown in Table 9.

Table 9

*Mean Ratings of Terminal Values by Age Group of Participants (N = 24)*

| | *M* | | |
|---|---|---|---|
| Terminal Value | 30-39 (*n* = 7) | 40-49 (*n* = 9) | 50-59 (*n* = 8) |
| Comfortable Life | 7.44 | 11.00 | 7.00 |
| Equality | 10.66 | 8.25 | 8.00 |
| Exciting Life | 10.66 | 8.25 | 12.43 |
| Family Security | 5.67* | 2.75* | 3.71* |
| Freedom | 8.44 | 8.38 | 5.00* |
| Health | 4.00* | 2.50* | 3.29* |
| Inner Harmony | 8.78 | 5.25 | 7.43 |
| Mature Love | 5.00* | 9.25 | 10.86 |
| National Security | 11.56 | 9.75 | 9.86 |
| Pleasure | 8.44 | 12.75** | 12.86** |
| Salvation | 8.78 | 3.25* | 5.57 |
| Self Respect | 7.11 | 7.38 | 7.14 |
| Sense of Accomplishment | 9.44 | 10.75** | 9.57 |
| Social Recognition | 10.33 | 13.38** | 15.57** |
| True Friendship | 9.11 | 12.13 | 10.43 |
| Wisdom | 12.67** | 10.25 | 9.86 |
| World at Peace | 15.44** | 10.25 | 11.14 |
| World of Beauty | 15.78** | 11.13 | 15.71** |

*Note.* * = Most important, ** = Least important.

The 30-39 age group has the lowest number of respondents (*n* = 7). The lowest terminal value mean scores were health (*M* = 4.0) followed by mature love (*M* = 5.0) and family security (*M* = 5.67). Both health and family security were the two most important terminal values of the overall sample. The lowest ranked (highest mean scores) were world of beauty (*M* = 15.78), followed by world at peace (*M* = 15.44).

In the 40-49 age group ($n$ = 9), there was consistency among low mean rankings as evidenced in health ($M$ = 2.50) and family security ($M$ = 2.75). The third lowest mean score was salvation ($M$ = 3.25), which is also the third lowest mean score of the overall sample. The least important terminal values, as evidenced by their high rankings, were social recognition ($M$ = 10.75), pleasure ($M$ = 12.75), and true friendship ($M$ = 12.10). The ranking of true friendship is different from that of the overall sample and the other age groups. The 50-59 age group ($n$ = 8) ranked health ($M$ = 3.29) as most important. The next most important value was family security ($M$ = 3.71). The least important value (highest mean score) for this age group was world of beauty ($M$ = 15.71), followed by social recognition ($M$ = 15.57). World of beauty was the least important value (highest mean ranking) ($M$ = 15.33) in the overall sample and in two of the three age groups, with 40-49 as the exception.

Across all three age groups, health and family security were rated as first, second, or third among the most important terminal values, which is consistent with the overall sample. There were slight variations between the age groups and the sample. In the 30-39 age group, mature love was rated as the third most important value, which was different from the other two age groups and the overall sample. In the 40-49 age group, sense of accomplishment was rated as the second least important, which was the only variation from the other two age groups. Overall, there was consistency in the rankings of the three age groups in terms of instrumental values (Table 10).

Table 10

*Mean Ratings of Instrumental Values by Age Group of Participants (N = 24)*

| | *M* | | |
|---|---|---|---|
| Instrumental Value | 30-39 (*n* = 7) | 40-49 (*n* = 9) | 50-59 (*n* = 8) |
| Ambitious | 8.44 | 8.13 | 15.00** |
| Broadminded | 8.89 | 7.63 | 12.57 |
| Capable | 8.22 | 7.50 | 7.00* |
| Clean | 12.11 | 12.75** | 12.57** |
| Courageous | 9.78 | 9.75 | 10.43 |
| Forgiving | 12.67** | 11.88 | 10.00 |
| Helpful | 11.89 | 6.63* | 7.14 |
| Honest | 5.28* | 3.63* | 3.00* |
| Imaginative | 12.33** | 11.88 | 13.14** |
| Independent | 4.44* | 11.25 | 10.14 |
| Intellectual | 4.78* | 11.88** | 9.29 |
| Logical | 10.67 | 11.00 | 11.29 |
| Loving | 10.22 | 10.25 | 9.29 |
| Loyal | 9.22 | 12.25** | 7.57 |
| Obedient | 11.11 | 9.75 | 7.29 |
| Polite | 8.89 | 9.88 | 8.29 |
| Responsible | 7.33 | 5.50* | 5.00* |
| Self-controlled | 12.56** | 11.00 | 10.29 |

*Note.* * = Most important, ** = Least important

Honest is the most important value in two of the three age groups (40-49, *M* = 3.63) and (50-59, *M* = 3.0) and the third most important value in the 30-39 age group (*M* = 5.28) as well as the most important instrumental value (*M* = 4.67) in the overall sample. In both the 40-49 and 50-59 age groups, responsible is the next most important instrumental value, with mean ranks of 5.5 and 5.0, respectively. Responsible is among

the top four of the most important values in the 30-39 age group (*M* = 7.33) and the second most important instrumental value of the entire sample (*M* = 6.96). Of the least important instrumental values (highest mean ranks) imaginative had the highest mean values in two of the three age groups, with mean scores ranging from 12.33 (30-39 age group) to 13.14 (50-59 age group). Imaginative was among the top four least important values (highest mean score) in the 40-49 age group (*M* = 11.88) and had the lowest rank (*M* = 12.68) in the overall sample. Of particular note was that clean was among the four lowest instrumental values in importance among these three age groups, means ranging from 12.11 to 12.75, and 11.52 in the overall sample. The low mean values in the 30-39 age group for independent (*M* = 4.44) and intellectual (*M* = 4.78) were in contrast to those of the other two age groups and the overall sample for independent (*M* = 8.52) and intellectual (*M* = 8.93). These scores also were in contrast to the high mean score for intellectual (*M* = 11.88) in the 40-49 age group. Another difference was found in the 50-59 age group, for whom ambitious was ranked as least important instrumental value (*M* = 15) versus the 30-39 age group (*M* = 8.44), 40-49 age group (*M* = 8.13) and the overall sample (*M* = 9.26).

In the instrumental category, honest was the common value among the top most important of the three age groups and the overall sample. There was some variation among the mean scores in the 30-39 age group for independent (*M* = 4.44) and intellectual (*M* = 4.78) and the 40-49 age group (independent, *M* = 11.25; intellectual, *M* = 10.14) and 50-59 age group (independent, *M* = 11.88; intellectual, *M* = 9.29) as well as the overall sample (independent, *M* = 8.52; intellectual, *M* = 8.93). Another difference was seen in the rating of broadminded in the 50-59 age group (*M* = 15.00) versus the

other two age subgroups, with mean scores of 8.13 and 8.44, and the overall sample, with a mean score of 9.33. The last terminal value that had some differences in ratings was helpful in the 30-39 age group ($M$ = 11.89) versus the 40-49 age group ($M$ = 6.63) and the 50-59 age group ($M$ = 7.14). There were no noteworthy differences in the age groups related to the least important values.

*Gender.* As noted above, the sample consisted of 30% male ($n$ = 8) and 70% female ($n$ = 19) respondents. The females' lowest mean values were health ($M$ = 2.42), family security ($M$ = 4.95), and salvation ($M$ = 6.21), reflective of the highest importance in value rankings. These rankings were consistent with the most important terminal values of the overall sample: health ($M$ = 4.11), family security ($M$ = 4.41), and salvation ($M$ = 6.33). The male category also ranked health ($M$ = 2.63) and family security ($M$ = 3.13) as the two most important values. This was followed by comfortable life ($M$ = 6.50), whose mean for overall sample was 9.15 and, for females, was 10.26.

The highest ranked instrumental values of both male and female respondents were consistent with those of the sample: world of beauty (male, $M$ = 16.13; female, $M$ = 15), world at peace (male, $M$ = 14.25; female, $M$ = 12), and social recognition (male, $M$ = 13.25; female, $M$ = 12.16). Health and family security remained consistently the first and second most important rated terminal values by gender. One variation in ratings was seen in comfortable life, with males' mean of 6.50 versus 10.26 for females. The last noteworthy variation in this subgroup was for the terminal value of self-respect with males' mean of 10.25 versus a mean for females of 6.79. Terminal values data by gender of participant are displayed in Table 11.

Table 11

*Mean Ratings of Terminal Values by Gender (N =27)*

| | *M* | |
|---|---|---|
| Terminal Value | Male (*n* = 8) | Female (*n* = 19) |
| Comfortable Life | 6.50* | 10.26 |
| Equality | 8.63 | 8.84 |
| Exciting Life | 10.86 | 12.00** |
| Family Security | 3.13* | 4.95* |
| Freedom | 6.88 | 7.68 |
| Health | 2.63* | 2.42* |
| Inner Harmony | 8.88 | 7.32 |
| Mature Love | 8.75 | 8.21 |
| National Security | 9.38 | 10.47 |
| Pleasure | 10.13 | 11.47 |
| Salvation | 6.62 | 6.21* |
| Self Respect | 10.25 | 6.79 |
| Sense of Accomplishment | 11.25 | 9.11 |
| Social Recognition | 13.25** | 12.16** |
| True Friendship | 11.88 | 9.63 |
| Wisdom | 11.88 | 10.42 |
| World at Peace | 14.25** | 12.00** |
| World of Beauty | 16.13** | 15.00** |

*Note.* * = Most important, ** = Least important.

There are few differences in the results for instrumental values by gender, as presented in Table 12. The findings are consistent with the most important instrumental values in the overall sample. Honest (male, *M* = 5.75; female *M* = 2.63) remained the most important instrumental value (*M* = 4.67). Responsible was the second most important value (male, *M* = 5.88; female, *M* = 7.42), which was also found for the overall

sample (*M* = 6.96). The third most important instrumental value was capable (male, *M* = 6.25; female *M* = 7.47), compared with the overall sample (*M* = 7.11). There was a difference in mean rankings in the value of loyal, with males having a mean of 7.88 and females having a mean of 10.68. (*M* = 10.68). There were differences in the least important instrumental value rankings by gender.

Table 12

*Mean Ratings of Instrumental Values by Gender (N =27)*

| | *M* | |
|---|---|---|
| Instrumental Value | Male (*n* = 8) | Female (*n* = 19) |
| Ambitious | 8.88 | 9.37 |
| Broadminded | 9.75 | 9.16 |
| Capable | 6.25* | 7.47* |
| Clean | 12.00** | 11.37 |
| Courageous | 10.63 | 8.84 |
| Forgiving | 10.25 | 11.84** |
| Helpful | 9.38 | 8.79 |
| Honest | 5.75* | 2.63* |
| Imaginative | 11.25 | 13.21** |
| Independent | 8.00 | 8.58 |
| Intellectual | 8.38 | 9.16 |
| Logical | 10.75 | 11.21 |
| Loving | 10.00 | 10.21 |
| Loyal | 7.88 | 10.68 |
| Obedient | 12.00** | 9.32 |
| Polite | 11.63 | 8.79 |
| Responsible | 5.88* | 7.42* |
| Self-controlled | 13.63** | 11.42** |

*Note.* * = Most important, ** = Least important.

## *Organizational Values*

There are five organizational values at SFMC: (a) respect, (b) compassionate service, (c) simplicity, (d) advocacy for the poor, and (e) inventiveness to infinity (Brown, 2006). Establishing consistency between the RVS's terminal and instrumental values and the Vincentian values that drive the mission of SFMC was an essential part of the study. Identifying consistent values and determining the level of alignment with the organization were the steps needed before congruence could be determined. This section presents the values comparisons, carried out by DOC content experts, between Vincentian values and the RVS terminal and instrumental values ratings. Additionally, a determination was made of which consistent values were highly, moderately, or somewhat aligned with the organization.

### *Comparisons between Vincentian Values and RVS Values by the Expert Panel*

The researcher met with the Vice President of Mission Integration at SFMC, who suggested that she and two other sisters from the Daughters of Charity were qualified to study the two sets of values, organizational and Rokeach, to determine their congruence. The three sisters are considered participant experts based on their vast experience, responsibility, and oversight of mission integration in their respective local health ministries. The researcher developed a grid that was mailed electronically to the three content expert sisters for their completion.

It was possible that a terminal or instrumental value was not necessarily consistent with any of the Vincentian values. If all three experts made value determinations consistent with at least one of the five Vincentian values that corresponded to a terminal or instrumental value of the RVS, this was considered an organizational value. Once the

sisters determined which RVS values were consistent with those of SFMC, further analysis was conducted to determine whether the value was highly aligned, moderately aligned, or somewhat aligned with SFMC values.

*Comparisons of Rokeach terminal values with Vincentian values.* The rankings by the expert panel were based on the definitions provided, and each was asked to consider whether she felt that the Rokeach values were consistent with the core values of St. Vincent de Paul. According to the panel, of the 18 terminal or "end-state" values, 6 (33%) were consistent with the Vincentian values. Consistent values included equality, family security, inner harmony, self-respect, a sense of accomplishment, and wisdom.

*Comparisons of Rokeach instrumental values with Vincentian values.* Of the 18 instrumental values or "modes of conduct," 11 (61%) were considered consistent with Vincentian values. For terminal values, however, only 6 of 18 (33%) were rated as consistent with Vincentian values and included broadminded, capable, courageous, forgiving, helpful, honest, imaginative, loving, loyal, responsible, and self-controlled.

*Final list of Rokeach values consistent with organizational values.* The complete list of both terminal and instrumental values is presented in Table 13. Of the combined Rokeach categories of values, 17 of 36 (47%) were considered consistent with the organization's values by the panel of experts. Those terminal values considered *not* consistent with the organization included comfortable life, an exciting life, freedom, health, mature love, national security, pleasure, salvation, social recognition, true friendship, world at peace, and world of beauty. Of the instrumental values, those *not* considered consistent with the organization were: ambitious, clean, independent, intellectual, logical, obedient, and polite.

Table 13

*Expert Ratings of Rokeach's Terminal and Instrumental Values with Vincentian Values*

| Value | Expert 1 | Expert 2 | Expert 3 |
|---|---|---|---|
| Terminal Values | | | |
| COMFORTABLE LIFE A prosperous life | 0 | 0 | 0 |
| EQUALITY* Brotherhood and equal opportunity for all | 1 | 1 | 1 |
| AN EXCITING LIFE A stimulating, active life | 0 | 0 | 0 |
| FAMILY SECURITY* Taking care of loved ones | 1 | 1 | 1 |
| FREEDOM Independence and free choice | 1 | 1 | 0 |
| HEALTH Physical and mental well-being | 1 | 0 | 1 |
| INNER HARMONY* Freedom from inner conflict | 1 | 1 | 1 |
| MATURE LOVE Sexual and spiritual intimacy | 1 | 1 | 0 |
| NATIONAL SECURITY Protection from attack | 1 | 0 | 0 |
| PLEASURE An enjoyable, leisurely life | 0 | 0 | 0 |
| SALVATION Saved; eternal life | 0 | 1 | 1 |
| SELF-RESPECT* Self-esteem | 1 | 1 | 1 |
| SENSE OF ACCOMPLISHMENT* A lasting contribution | 1 | 1 | 1 |
| SOCIAL RECOGNITION Respect and admiration | 1 | 1 | 0 |
| TRUE FRIENDSHIP Close companionship | 1 | 1 | 0 |
| WISDOM* A mature understanding of life | 1 | 1 | 1 |
| WORLD AT PEACE A world free of war and conflict | 1 | 1 | 0 |
| WORLD OF BEAUTY Beauty of nature and the arts | 0 | 1 | 0 |
| Instrumental Values | | | |
| AMBITIOUS Hardworking and aspiring | 0 | 1 | 0 |
| BROADMINDED* Open-minded | 1 | 1 | 1 |
| CAPABLE* Competent; effective | 1 | 1 | 1 |
| CLEAN Neat and tidy | 0 | 1 | 0 |
| COURAGEOUS* Standing up for your beliefs | 1 | 1 | 1 |
| FORGIVING* Willing to pardon others | 1 | 1 | 1 |
| HELPFUL* Working for the welfare of others | 1 | 1 | 1 |
| HONEST* Sincere and truthful | 1 | 1 | 1 |
| IMAGINATIVE* Daring and creative | 1 | 1 | 1 |
| INDEPENDENT Self-reliant; self-sufficient | 0 | 1 | 0 |
| INTELLECTUAL Intelligent and reflective | 0 | 1 | 0 |
| LOGICAL Consistent; rational | 0 | 0 | 0 |
| LOVING* Affectionate and tender | 1 | 1 | 1 |
| LOYAL* Faithful to friends or the group | 1 | 1 | 1 |
| OBEDIENT Dutiful; respectful | 1 | 1 | 0 |
| POLITE Courteous and well-mannered | 0 | 1 | 0 |
| RESPONSIBLE* Dependable and reliable | 1 | 1 | 1 |
| SELF-CONTROLLED* Restrained; self-disciplined | 1 | 1 | 1 |

*Note:* Values in upper case are Rokeach's values. 0 = Consistent with Vincentian values; 1 = Not consistent with Vincentian values. Values with an * indicate those that met the required unanimous rating by the expert panel or were considered to be consistent with organizational values.

If two of the three experts agreed on consistency, the extent of alignment of each value was determined. Both terminal and instrumental consistent values were categorized by the expert panel into three levels of alignment: highly aligned, moderately aligned, or somewhat aligned (Table 14).

Table 14

*Rokeach's Values Consistent and Aligned with the Organization's Vincentian Values*

| Value | Highly Aligned | Moderately Aligned | Somewhat Aligned |
|---|---|---|---|
| Terminal Values | | | |
| Self-respect | 3 | | |
| Equality | 2 | 1 | |
| Family Security | | 2 | 1 |
| Inner Harmony | 1 | 1 | 1 |
| Sense of Accomplishment | 1 | 1 | 1 |
| Wisdom | 1 | 1 | 1 |
| Instrumental Values | | | |
| Helpful | 3 | | |
| Honest | 3 | | |
| Loving | 3 | | |
| Responsible | 3 | | |
| Courageous | | 3 | |
| Broadminded | 1 | 2 | |
| Capable | 2 | 1 | |
| Forgiving | 2 | 1 | |
| Imaginative | 1 | 2 | |
| Loyal | 2 | 1 | |
| Self-controlled | 1 | 2 | |

*Note.* Numbers represent how many experts agreed in each category of alignment.

Of the six terminal values, two, self-respect and equality, were considered by the sisters as being highly aligned and one, family security, was considered moderately aligned with the organization. The other values had broad distribution of extent of alignment by the panel. For instrumental values, seven were felt to be highly aligned with the organization's values and four were considered to be moderately aligned. The other instrumental values, although consistent with the organization, were considered to be at different levels of alignment by the expert panel.

*Congruence of the RN Sample's Values and the Organization's Values*

The results of the alignment process enabled a clear definition and process for determining the nature of the congruence between the RNs' individual values and those of the organization. High congruence was determined if the values rated as most important to the nursing staff were those that were considered most highly aligned by the panel. In the terminal value set, there was high congruence in self-respect because this value was one of those considered most important by the nurses (within the top six values); however, equality was not considered a most important value by the nurses and is therefore considered to have a moderate level of congruence. For the instrumental values set, high congruence existed in the values of capable, helpful, honest, and responsible as they were rated as most important by the nurses (within top 11 values); however, forgiving, loving, and loyal were not rated as most important and were not considered to have high congruence. The high congruence values are presented in Table 15.

Table 15

*Mean Rankings of the Organizational Values with High Congruence*

| Value | *M* |
|---|---|
| Terminal | |
| Self-respect | 7.81 |
| Instrumental | |
| Honest | 4.67 |
| Responsible | 6.96 |
| Capable | 7.11 |
| Helpful | 8.96 |

A moderate level of congruence was determined only if some of the values rated as most important were those identified by the panel as being highly aligned or if only the values that were rated as being only moderately aligned by the sisters were those rated as most important. In the terminal values set, family security was considered only moderately aligned by the sisters, but the RNs identified this as the second most important value, thereby giving it a moderate level of congruence. In the instrumental set, the values loving and forgiving were considered highly aligned by the panel, yet not ranked as most important by the RNs, resulting in a moderate level of congruence. Broadminded and courageous values were rated as moderately aligned by the sisters but as most important by the nurses, yielding a moderate level of congruence (Table 16).

Table 16

*Mean Rankings of the Organizational Values with Moderate Congruence*

| Value | *M* |
|---|---|
| Terminal | |
| Family Security | 4.41 |
| Equality | 8.78 |
| Instrumental | |
| Broadminded | 9.33 |
| Courageous | 9.37 |
| Loving | 10.15 |
| Forgiving | 11.00 |

A low level of congruence existed if more of the values rated as most important by the RNs were not considered at least moderately or highly aligned with those of the organization. Low congruence would also exist if a substantial number of the values considered as highly aligned by the sisters were rated as the least important by the RNs. From the terminal value set, inner harmony was identified as the fifth most important value, yet there was no agreement on the alignment by the sisters and, as such, it considered having a low level of congruence (Table 17). None of the instrumental values met low level congruence criteria.

Table 17

*Mean Ranking of the Organizational Value with Low Congruence*

| Value | *M* |
|---|---|
| Terminal | |
| Inner Harmony | 7.78 |

*Summary*

Findings showed consistency between the survey tool's instrumental and terminal values and Vincentian values (17 of 36), and alignment with the organizations' values measured in high (9 of 17) and moderate (5 of 17) levels. There were varying levels of congruence between the nurses' personal values and the organizational values. High levels of congruence existed in the values of self-respect, capable, helpful, honest, loyal, and responsible. Moderate levels of congruence were found in the values equality, family security, broadminded, courageous, forgiving, and loving, and inner harmony had low congruence. Few differences were found among the demographic subgroups within the sample.

# Chapter 5

# Discussion

This chapter presents a discussion of the research findings, along with conclusions, implications, and recommendations. The chapter begins with the background, followed by the problem and purpose, key findings, conclusions, and methodological limitations. The chapter concludes with closing comments and recommendations.

## *Background*

The concerns facing America's hospitals today are complex and are related to local, state, and national challenges concerning economics and societal conditions. Compared to other major industrialized countries, we spend a larger share of our GDP (16%) (U.S. Department of Health and Human Services, 2007) on healthcare than on any other area. Healthcare expenditures are predicted to continue to rise at similar levels for the next several years, reaching $4 trillion by 2015, or 20% of the GDP (Borger et al., 2006). Over 47 million people within this country lacked insurance of any kind in 2006 (Employee Benefit Research Institute, 2008), and between 2000 and 2006, the number of uninsured grew by 9.4 (Hoffman et al., 2007).

## *Problem and Purpose*

There are no simple solutions to the declining performance faced by many of our institutions. Among the factors that contributed to declining performance were decreasing profit margins due to changing demographics, lower reimbursements, rising numbers of uninsured patients, increasing costs associated with labor organizations, quality issues, growing consumer demand, and healthcare practitioner shortages. Specifically, nursing

shortages, scheduling pressures driven by mandatory staffing requirements, and increasing labor costs of registered nurses disproportionate to hospital income were among many contributors that shifted the focus of the nurse from patient care to personal demands and needs indicative of a survival mode.

While the external factors are beyond the scope of this study, the researcher chose to focus on the intrinsic factor of nurses' values in one case hospital and whether they were congruent with those of one of its founders, St. Vincent de Paul. RNs comprise the majority of hospital resources, and assessing their values is important because they have a major effect on patients' safety and clinical outcomes.

From a sociological perspective, Bellah et al. (1991) described a gap between *technical reasoning* based on knowledge and *moral reasoning* based on values in our current society. Moreover, there is a widening gap between affluence that drives consumption and the large numbers of poor, indigent, and homeless who are frequently sick as a direct result of a lack of food, shelter, and preventive medical care. The Catholic hospital under study has strong organizational (Vincentian) values and a mission to serve the sick and poor that may be perceived as counter-cultural to today's societal norms.

Vincentian values include respect, compassionate service, simplicity, advocacy for the poor, and inventiveness to infinity. Vincentian institutions carry a responsibility for the greater good of society by the continuation of the Vincentian character and mission. Due to the declining number of religious in our society and in our faith-based institutions, increasing numbers of laity are being recruited to assume more leadership roles. To continuously renew Vincentian culture with religious and lay people, including nurses, individuals need to be inspired and committed to the higher purpose of their

Vincentian institution. The shift in societal values and norms make it even more important to assess the internal values of the nursing staff and to determine whether there is congruence between their values and those of the hospital.

The purpose of the case study was to assess whether there is congruence between nurses' personal values and the organization's Vincentian values. The results of this study can be used to develop tools and strategies intended to enhance clinical nursing practice and alter culture within the organization to re-focus on the provision of values-based care. The aim of this study was to promote higher levels of nursing engagement, resulting in improved quality patient care, prevention of patient harm, desired clinical outcomes, and improved nurse satisfaction.

*Conceptual Support*

Personal values influence the attitudes, thoughts, and actions of individuals. Research has determined that, when the personal values of employees and those of an organization are aligned, employees will perform at a higher level. This is known as values congruence and it is the connection between employee values that drive decisions and actions and the organizational values that establish the facility's normative behavior. (Chatman, 1989; Kristoff, 1996; Rokeach, 1973; Schwartz, 1992). Research has shown positive outcomes when there is congruence between personal and organizational values (Amos & Weathington, 2008; Boxx, Odom, & Dunn, 1991; Posner, 1992; Ugboro, 1993). Consequently, if registered nurses' values are aligned with the hospital's values, they are more likely to perform at a higher level, producing better clinical outcomes. There is no published research specifically on the values of healthcare professionals and

the alignment of their values to those of the organization, which demonstrates a need for this study.

*Organizational effectiveness*. Covey (1990) described transforming an organization only after personal character and interpersonal relations based on principles have been established. His framework asserts that people (nurses) will not adapt to external reality or willingly change with commitment and desire until there is internal security. The concept of managing by values is a broader approach to organizational effectiveness based on mission and values recommended for organizations that face increasing complexity, competitive challenge, and a high rate of change (Blanchard & O'Connor, 1997). Putting this concept into context, hospitals need a care delivery model based on “caring by values” versus “managing by values.”

*Leadership*. Drawn from the business literature, a transformational leadership model that includes bringing heart (values), soul, and spirit into the workplace to gain more favorable organizational results could translate into better clinical outcomes and ultimately organizational effectiveness (Kouzes & Posner, 2003). St. Vincent de Paul and Louise de Marillac demonstrated long-lasting examples of values referred to as the “heart of change” in their actions and teachings. Most notable was their commitment to higher purpose, empowering others within their organizations, and sharing vision of service to the poor (Posig, 2005), all reflective of alignment between personal and organizational values.

*Values in healthcare.* An extensive database survey of empirical research on values of healthcare professionals determined that the majority of existing research has been focused on ethics and moral reasoning as opposed to individual values of healthcare

professionals (Frederick et al., 2000). The nursing research available is most commonly tied to ethics and moral judgment and the development of normative theory and concepts (Omery, 1989; Raines, 1994; Thurston et al., 1989; Viens, 1995). There is only a limited body of knowledge on registered nurses' values, justifying the need for this study.

*Methods*

Based on the paucity of research on this topic, an exploratory approach was chosen. Specifically, a quantitative case study research design was selected to produce information and create knowledge that could influence future leadership strategy and management direction. Data collection used a survey method, incorporating the RVS, which was modified for electronic use and made available at the work site to registered nurses over a 2-week survey period.

The sample consisted of self-selected RNs from a targeted population of over 700 full- and part-time registered nurses working in a single hospital environment. The primary source of data was each individual nurse who ranked his or her values using the RVS. Two types of personal values, instrumental and terminal, were ranked by the nurses and are based on enduring beliefs related to specific modes of conduct or end-states of existence that are considered personally or socially preferable to opposite or converse modes of conduct or end-states (Rokeach, 1967). The RVS was automated for this study on *Survey Monkey* and linked to the hospital intranet with a dedicated icon for easy identification to be completed at the convenience of each participant, who could access the survey in his or her assigned work environment as well as at other select intranet access points within the hospital. Participants' demographics, including age, gender, religion, and ethnicity, also were collected.

Consistency between the Vincentian values and the RVS values was determined by three content expert sisters from DOC. This process resulted in 17 of the 36 RVS values (47%) deemed consistent with Vincentian values. The expert panel also determined the extent of each value's alignment with the organization's values. There were three levels of extent: highly aligned, moderately aligned, or somewhat aligned. This rating allowed for the determination of the degree of congruence between the nurses' and the organization's values.

### *Key Findings*

Due to the considerable methodological limitations of the study, particularly the small sample size, the results are inconclusive. The aim to produce information and create knowledge that would influence future leadership strategy and management behavior was not able to be met. Nevertheless, analyses were performed on the sample and some conclusions could be generated that contribute to learning for the researcher and the organization.

Four specific key findings were evident. First, there was consistency for a substantial number of the RVS instrumental and terminal values and Vincentian values. The expert panel of three sisters unanimously agreed that 17 of the 36 values (47%) were consistent with the organization's values.

Second, there was further assessment by the sisters of the extent to which a specific consistent value was aligned with the organization's values. High alignment was determined for 9 of the 17 (53%) values and moderate alignment for 5 of the 17 (29%). There was no agreement on the values that were considered somewhat aligned.

Third, there were varying levels of congruence between the nurses' personal values and the organizational values of SFMC. Due to the small sample size, there is insufficient data to suggest that such congruence exists for the broader target population.

Fourth, there were few differences based on the demographic subgroups of religious, ethnicity, age, and gender as compared to the overall sample. In general, the findings of the demographic subgroups reflected those of the overall sample.

### *Conclusions*

The purpose of this study was to determine whether congruence existed between individual nursing values and those of the organization. It can be concluded that varying levels of congruence existed with this sample of nurses.

Of the nine highly aligned values identified by the expert panel, six were also ranked as most important by the RN participants, resulting in a high level of congruence. Six were also identified as having a moderate level of congruence, based on the researcher's criteria. Only two of the moderately aligned values, imaginative and self-controlled, did not meet congruence criteria due to the rankings being too low by the RN sample. Those values with high levels of congruence (self-respect, capable, helpful, honest, and loyal) appeared to be logical choices by both sisters and nurses who have built their calling/career on serving/helping others to promote and/or improve their overall well being. There was a discrepancy between the nurses' rankings of health and salvation in the top three most important categories and the sisters' lack of agreement about the consistency of these values.

Another difference was found for the values of imaginative and self-controlled, both considered consistent and moderately aligned with the organization by the sisters,

yet ranked very low by the RN sample. There were far fewer terminal or "end-state" values determined to be consistent or aligned compared to instrumental or "mode of conduct" values. This is consistent with Rokeach's intention of the end-states of personal values and not those necessarily of an organization. The "modes of conduct" values are more process-based and may suggest being more adaptable to an organization's values.

Several conclusions about the methods used require discussion. First, the procedure for determining consistency between the RVS terminal and instrumental values and the Vincentian values by the expert panel proved to be an effective approach. The development of the grid, the use of email to communicate with the content experts, and the two-thirds rating method to determine consistency were all effective.

The RVS was an appropriate instrument to use because it was comprehensive in scope, as are values of St. Vincent de Paul. This conclusion was based on the new knowledge that resulted from two of the three sisters' determination of the Rokeach values considered to be consistent with the five Vincentian values the majority of the time (69%). All five of the Vincentian values were represented by the RVS terminal and instrumental values. Thus, the use of the RVS for this targeted population was a good choice in terms of conducing Vincentian values in healthcare research. The additional assessment made by the three sisters on the RVS values that they considered consistent with Vincentian values and identifying whether they were highly, moderately, or somewhat aligned with the organization's values was also valuable to the study.

Although the sample size was considerably smaller than desired, the results are promising and provide support for the appropriateness of the conceptual framework of this study. The determination of congruence between the nurses' personal values and

those of St. Vincent de Paul, as revealed by the top five ranked values of the RVS, suggests alignment between individuals' values and those of the hospital. The results from this sample suggest a parallel between congruence and what Covey (1990) refers to as internal security, which must precede organizational transformation, i.e., to achieve organizational effectiveness, personal values must precede an alignment with organizational values. The data also support Blanchard and O'Connor's (1997) managing/caring by values leadership framework for a work (care) environment such as SFMC's, which is based on a mission and values.

### *Methodological Limitations*

This study had a number of methodological limitations related to sampling, data collection strategies and instrumentation, the use of a survey method, and some researcher assumptions. Each of these limitations is discussed below.

#### *Sampling*

The sample data had to be reduced by 74% from the 105 survey responses, which threatened the meaning, relevance, and significance of the results. The targeted population of 731 RNs could have produced a sufficient sample. However, there were competing organizational priorities at the time of survey, it was voluntary, there were no incentives, the subject matter may have not been appealing, and it may have been under-marketed. One possible limitation was ruled out; the RNs did not feel coerced by the researcher's position of chief nurse executive and, as such, did not feel compelled to complete the survey. However, it must also be noted that the relationship could have been as much a disincentive as an issue of coercion.

In addition to the letter sent to the RNs' homes and the posters in the patient care areas, more frequent handouts, daily computer screen reminders, or soliciting participation in the patient care areas could have solicited more participation. Although there is always debate over the use of incentives, a coupon for a drink or meal ticket for the coffee cart or cafeteria may have improved the response rate.

*Instrument*

There were several limitations related to the survey instrument. The augmentation of the manual tool to electronic format posed a number of problems. By modifying the RVS from its original paper format to an electronic version, problems with the ranking procedures were apparent. The first issue had to due with mechanics of the conversion. Several electronic products for survey administration were assessed and *Survey Monkey* was deemed the most suited for the researcher's needs. Forced ranking would have been ideal, but the listing for forced ranking was limited by 16 entries by *Survey Monkey* design, and each value set was 18.

It is relatively easy to assess most important and least important values for most, but rank ordering all that lie in the middle and sequencing the numbers in rank appropriately may have been too great of a task without a forced ranking feature. The pilot on the tool failed to pick up this limitation. Numerous multiple rankings resulted in compromised internal validity and caused elimination of many completed surveys. Based on the results, manual administration of the survey, followed by electronic entry, would have been a better choice for administering the RVS.

Other limitations of the instrument may have to do with the weaknesses identified in the RVS in the literature. One identified weakness of the RVS was based on the

assumption that all participants have a personal value system in which there is a strict rank ordering of the value elements (Kitwood, 1982). Perhaps there is some truth to this inability to rank order one's values or in the pervasive belief that humans cannot remember numerical sequences of more than five to seven numbers. When the tool was manual, there was no variability in the use of the gummed labels and being able to match them to the list of values in each set. When the modification to the electronic format took place, the variability was increased and the process became unreliable. Therefore, changing the tool structure from a ranking to a Likert scale could prove beneficial for future studies.

The other weakness was identified by Gibbins and Walker (2001); they noted variance in how participants interpret the meaning of the values. Due to the problems with data collection, particularly the small sample size, the reliability of the RVS could not be assessed, and thus Gibbins and Walker's concerns with reliability could not be addressed.

*Survey Method*

The use of a survey method may have been a limitation due to the weaknesses of such a method, which include: (a) use of one strategy, (b) non-cyclical and non-emergent data collection, (c) non-participatory/not interactive inquiry, and (d) a limited versus a broad view of information. Incorporating more than one research method in the study design, such as utilizing an action research approach with forums, interviews, or other qualitative data measures, may have been a more comprehensive and effective method for this study.

*Researcher Assumptions*

Other limitations were related to some of the researcher's assumptions. For example, as the surveys were completed, the researcher checked, on a regular basis, the number of surveys marked "complete" in *Survey Monkey* during the data collection period. However, the surveys were not opened and data were not examined for accurate ranking. The researcher assumed that the instrument's request for the ranking of 18 items would work as the literature had stated. However, the electronic modality did not enable ease of assigning the 18 rankings in the same way that the use of stickers on paper allowed. Had the problem been recognized during the survey collection, modifications to the electronic interface could have been made. It became clear that the initial pilot of the tool was not sufficient to reveal these problems with ranking. In hindsight, the individuals selected to serve in the pilot study received more instruction and were aware of the importance of a complete ranking than were the participants in this study.

*Closing Comments and Recommendations*

From the researcher's perspective, although there were several important limitations to this study, it was a valuable learning experience, particularly in regard to the research process. Although the results were based on a small sample, they suggest that readiness for transformation may exist indicated by the most important values endorsed by the RN participants and their congruence with organizational values. Through an understanding of the congruence of nursing and organizational values, hospital managers and educators also can provide advice and coaching that is appropriate to and consistent with fulfilling patients' needs as well as the hospital's mission and service to its community.

The relevance to nurses and the hospital organization of the foundational concepts of the research should be explored, particularly the concept of transformational readiness. According to Covey (1990), one cannot transform an organization into a total quality culture unless and until basic habits of personal character and interpersonal relations based on principles (values) are built within the workforce. Having the foundation to make quality changes and to have them take hold is critical to achieving organizational effectiveness.

The reliability of the RVS in electronic format was a concern. The issues during administration indicate that another delivery mode would have been more reliable as a testing method. The development of a new tool, utilizing the newly determined consistent values, would be a good starting point for future research.

Recruitment specialists and hospital educators can utilize the findings for leadership strategies, management direction, human resource management, staff professional development, and the creation of measurement tools. Recruitment, retention, and training of nursing associates can be based on determining which individuals have values that are similar to those of the organization. An understanding of value congruence may help hospital leaders to make decisions and develop strategic planning that are consistent with SFMC's mission, goals, and values.

Further research on Vincentian values in patient care could link the most important identified values to clinical work tasks in patient care areas. This would make it possible to align values with practice in a Vincentian-values based organization. Consideration also should be given to extending the sample within the defined population to include either other direct care providers such as LVNs, technicians, and nursing

assistants or other professional clinicians such as licensed dieticians, pharmacists, physical therapists, and respiratory care practitioners. The vast majority of research in values in hospitals has been based on nursing or medical student participants, and a new level of inclusiveness would break ground for values-based research.

The relationship between Vincentian values and other key areas such as communication, decision making, leadership, ethical decision making, patient care quality, and patient safety could prove helpful for planning, program development, and patient care models. The research avenues for Vincentian values in healthcare are almost as endless as the opportunities in healthcare and offer the possibility of solutions to the problems faced by healthcare in the U.S. today.

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# APPENDIX A

## Survey Instrument

Instructions

The following two pages list 18 values arranged in alphabetical order. Each value is accompanied by a short description and is printed on a gummed label that can be peeled off easily and placed in the boxes in the left-hand column of the page.

Your goal will be to rank each value in its order of importance to you. Study the list and think of how much each value may act as a guiding principle in your life.

To begin, select the value that is of most importance to you. Peel off the corresponding label and place it in Box 1. Next, choose the value that is second in importance to you and place its label in Box 2. Work your way through the list until you have ranked all 18 values on this page. The value that is of least importance to you should appear in Box 18.

When you have finished ranking all 18 values, turn the page and rank the next 18 values in the same way.

When ranking, take your time and think carefully. The labels can be moved from place to place so you can change their order should you have second thoughts about any of your answers. Where you have completed the ranking of both sets of values, the result should represent an accurate picture of how you really feel about what's important in your life.

| Labels | Terminal Values |
|---|---|
| 1 | comfortable life<br>*a prosperous life* |
| 2 | equality<br>b*rotherhood and equal opportunity for all* |
| 3 | exciting life<br>*a stimulating, active life* |
| 4 | family security<br>*taking care of loved one* |
| 5 | freedom<br>*independence and free choice* |
| 6 | health<br>*physical and mental well being* |
| 7 | inner harmony<br>*freedom from inner conflict* |
| 8 | mature love<br>*sexual and spiritual intimacy* |
| 9 | national security<br>*protection from attack* |
| 10 | pleasure<br>*an enjoyable, leisurely life* |
| 11 | salvation<br>*saved; eternal live* |
| 12 | self-respect<br>*self-esteem* |
| 13 | sense of accomplishment<br>*a lasting contribution* |
| 14 | social recognition<br>*respect and admiration* |
| 15 | true friendship<br>*close companionship* |
| 16 | wisdom<br>*a mature understanding of life* |
| 17 | world at peace<br>*a world free of war and conflict* |
| 18 | world of beauty<br>*beauty of nature and the arts* |

| Labels | Instrumental Values |
|---|---|
| 1 | ambitious<br>*hardworking and aspiring* |
| 2 | broadminded<br>*open-minded* |
| 3 | capable<br>*competent; effective* |
| 4 | clean<br>*neat and tidy* |
| 5 | courageous<br>*standing up for your beliefs* |
| 6 | forgiving<br>*willing to pardon others* |
| 7 | helpful<br>*working for the welfare of others* |
| 8 | honest<br>*sincere and truthful* |
| 9 | imaginative<br>*daring and creative* |
| 10 | independent<br>*self-reliant; self-sufficient* |
| 11 | intellectual<br>*intelligent and reflective* |
| 12 | logical<br>*consistent; rational* |
| 13 | loving<br>*affectionate and tender* |
| 14 | loyal<br>*faithful to friends or the group* |
| 15 | obedient<br>*dutiful; respectful* |
| 16 | polite<br>*courteous and well-mannered* |
| 17 | responsible<br>*dependable and reliable* |
| 18 | self-controlled<br>*restrained; self-disciplined* |

# APPENDIX B

## Congruence Grid

| Rokeach TERMINAL VALUES | Respect | Compassion | Simplicity | Advocacy | Inventive to Infinity | No Congruence |
|---|---|---|---|---|---|---|
| comfortable life | | | | | | |
| equality | | | | | | |
| exciting life | | | | | | |
| family security | | | | | | |
| freedom | | | | | | |
| health | | | | | | |
| inner harmony | | | | | | |
| mature love | | | | | | |
| national security | | | | | | |
| pleasure | | | | | | |
| salvation | | | | | | |
| self-respect | | | | | | |
| sense of accomplishment | | | | | | |
| social recognition | | | | | | |
| true friendship | | | | | | |
| wisdom | | | | | | |
| world at peace | | | | | | |
| world of beauty | | | | | | |
| Rokeach INSTRUMENTAL VALUES | Respect | Compassion | Simplicity | Advocacy | Inventive to Infinity | No Congruence |
| ambitious | | | | | | |
| broadminded | | | | | | |
| capable | | | | | | |
| clean | | | | | | |
| courageous | | | | | | |
| forgiving | | | | | | |
| helpful | | | | | | |
| honest | | | | | | |
| imaginative | | | | | | |
| independent | | | | | | |
| intellectual | | | | | | |
| logical | | | | | | |
| loving | | | | | | |
| loyal | | | | | | |
| obedient | | | | | | |
| polite | | | | | | |
| responsible | | | | | | |
| self-controlled | | | | | | |

Please mark one X in the respective column for respect, compassion, simplicity, advocacy, inventiveness to infinity, or “no congruence” in the row for each terminal or instrumental value listed above. This will indicate whether or not you see consistency between the Vincentian organizational value to the right of each terminal or instrumental personal value measure listed in the first column.

# APPENDIX C

## Letter of Introduction to Prospective Participants

October 27, 2008

Dear SFMC Registered Nurse:

I sincerely want to thank those of you from the Medical-surgical, ICU, Telemetry and Emergency Department units for your recent participation in the CMS/Premier/HQID survey. Your voice is important to me as your nursing leader, but more important to the profession of nursing at large. With that said, I would like to ask for your participation in another survey that is very specific to our practice environment and the delivery of nursing care at St. Francis Medical Center.

This research will focus on whether your personal values are congruent with those of our organization: the five Vincentian values of respect, compassionate care, simplicity, advocacy, and inventiveness to infinity. This values research on Vincentian values is limited to the religious and academic communities, and there is virtually no published research based on a healthcare setting. It is a well known fact that when employees' values are aligned with those of the organization, performance is enhanced. The information we receive from the data collection will be the basis for a focused plan on which target areas we may need to develop.

St. Francis Medical Center's nursing leadership is committed to striving for the delivery of excellent nursing care to every patient with every contact in a professional practice environment of which we are all proud. However, we do not fully understand the most important factors that will drive professional nursing at our local health ministry to achieve this aim. Based on what is learned, this will inform efforts to design inventiveness around personal and organizational values' congruence that will lend to optimal nursing performance and patient outcomes.

I am the principal investigator of the research study that will be submitted to Pepperdine University in partial fulfillment of the requirements for the degree of Doctor of Education in Organization Change. A valid and reliable survey tool will be used to measure the personal values data. There will be a survey link on the SFMC intranet with an icon labeled "RN Values Survey." The 2-week survey collection period will be from November 3, 2008 through November 17, 2008. You will be able to access any hospital computer with SFMC intranet capability during the survey period to take your survey. We will also have a designated computer set up for your convenience at the annual skills faire on November 11, 12, and 13. Completing the entire survey generally takes between 5 and 10 minutes. The survey has two sets of 18 personal values that are rank-ordered by selecting one value as the most important in a particular value set, followed by the next most important value, and so on. The results of this survey will be analyzed only in the aggregate (i.e., at the hospital level) and no individual nurse responses will be identified .

Your participation is voluntary. Clearly, this initiative is very important to us at SFMC but may also lead to assisting other faith-based hospitals within our system and beyond. Nurse participation in this initiative will be pivotal for creating knowledge that can be used to inform both clinical practice as well as management direction. Thank you in advance for your consideration of this request.

Sincerely,

Beverly Quaye, MN, RN, Ed.Dc
Vice President, Patient Care Services

# APPENDIX D

## SFMC IRB Letter

September 17, 2008

Beverly Quaye, MN, RN
V.P., Patient Care Services
St. Francis Medical Center
3630 E. Imperial Highway
Lynwood, CA 90262

Re: Inquiry on Rokeach Values Survey for Registered Nurses

Dear Beverly:

Thank you for your electronic mail dated July 29, 2008 regarding Criteria for IRB approval on anticipated research at St. Francis Medical Center (SFMC). As per our policy, your research on whether a correlation exists between registered nurses' personal values and the organization's Vincentian values does not require IRB approval from the SFMC IRB Committee. The purpose of our IRB is for clinical research that involves patients as human subjects, or abstracts utilizing medical records, and therefore does not require our approval. The medical staff wishes you every success in your research process and looks forward dot hearing about your results in the future.

Sincerely,

Van Miller, M.D.
Chairman
Institutional Review Board Committee

APPENDIX E

Pepperdine University IRB Approval Letter

# PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

October 28, 2008

Beverly Quaye
1482 New York Drive
Altadena, CA, 91001

Protocol No.: E1008D6
Project Title: *An Evaluation of Congruency of Nursing Staff Values and Organizational Vincentian Valu*es

Dear Ms. Quaye:

Thank you for submitting your revised IRB application, *An Evaluation of Congruency of Nursing Staff Values and Organization Vincentian Values,* to Pepperdine's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB has reviewed your revised submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 45 110 (research category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted Full Approval. The IRB approval begins today, October 28, 2008, and terminates on October 28, 2009. In addition, your application to waive documentation of consent, as indicated on your Application Waiver or Alteration of Informed Consent Procedures form, has been approved.

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For *any* proposed changes in your research protocol, please submit a Request for Modification Form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying from expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond October 28, 2009, a Continuation or Completion of Review Form must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.
A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research.

If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required, depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate.

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me on behalf of the GPS IRB. I wish you success in this scholarly pursuit.

Sincerely,

Doug Leigh, PhD
Associate Professor of Education
Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive, 5th floor
Los Angeles, CA, 90045
dleigh@pepperdine.edu
(310) 568-2389

CC: Dr. Lee Kabs, Associate Provost for Research & Assistant Dean of Research, Seaver College
Ms. Ann Kratz, Human Protections Administrator
Dr. Doug Leigh, Chair, Graduate and Professional Schools IRB
Ms. Jean Lee, Manager, Graduate and Professional Schools IRB
Dr. Kay Davis
Ms. Christie Dailo

APPENDIX F

Poster

# Nursing & Research

We Need Your Help!

**TO:** RNs Full and Part-time Housewide

**WHAT:** Completion of an RN Values Survey

**WHEN:** Monday, November 3, 2008
through
Monday, November 17, 2008

**WHERE:** SFMC Intranet
Click on “RN Values Survey”

**WHY:** ANCC Magnet Force #7
Quality Improvement: Staff nurses participate in the quality improvement process and believe that it helps improve patient care within the organization.

Add to the nursing profession's knowledge of nurse values and how, if aligned with organizational Vincentian values, they may affect clinical performance.

# What's in it for me?

- Have a voice
- Contribute to evidence-based nursing from a clinician's point of view
- Make a difference
- Continue to grow Nursing Research and Development at SFMC

TOGETHER WE CAN (AND WILL) DO GREAT THINGS!

St. Francis Medical Center
Our mission is life

# APPENDIX G

## Informed Consent

Copy of Informed Consent as it appeared at the beginning of the electronic survey.

I authorize Beverly Quaye, RN, MN, a doctoral student in the Graduate School of Education and Psychology at Pepperdine University, to include me in the research project titled "An Evaluation of Congruency of Nursing Staff Values and Organizational Vincentian Values." I understand that my participation in this study is strictly voluntary. I have been asked to participate in a research project that is designed to study registered nurses' personal values at St. Francis Medical Center to determine whether they are congruent with the five Vincentian values of the hospital.

The study will require the completion of the attached survey tool, including demographics and values' rankings. I have been asked to participate in this study because I am a full- or part-time registered nurse employed at the hospital. Values are known to drive behavior, and because I have responsibility for the coordination of care for my patients, my personal values influence my work behavior. I understand that the data collected on this survey are anonymous and will be used for research purposes only. The data will be stored on a secured computer that requires a security access code and a password used only by the researcher.

The only potential risk of participating in this study is a feeling of obligation due to the reporting relationship with the researcher, who is the Vice President of Patient Care Services. Because of this potential risk, the researcher will not solicit or coerce participation. Instead, a generic letter of introduction of the study, requesting voluntary participation has been sent to my home address.

I understand that there is no direct benefit from participation in the study; however, there are benefit(s) to the Patient Care Services department and to the profession's information regarding behavioral criteria that will enhance clinical performance in relation to organizational values and faith-based care. I understand that I have the right to refuse to participate in, or to withdraw from, the study at any time by simply exiting this survey and not completing or submitting it. I understand that no information gathered from my study participation will be released to others without my permission or as required by law.

If the findings of the study are published or presented to a professional audience, no personally identifying information will be released. The data will be maintained in a secure manner for 3 years, at which time the data will be destroyed. I understand that I will receive no compensation, financial or otherwise, for participating in the study.

I understand that if I have any questions regarding the study procedures, I can contact Beverly Quaye at (310) 900-7310 to get answers to my questions. If I have further questions, I may contact Dr. Kay Davis, Faculty Supervisor, Pepperdine University at

(310) 568-5660. If I have further questions about my rights as a research participant, I may contact Dr. Margaret Weber, Chairperson of the GPS Institutional Review Board, Pepperdine University at (310) 568-5615. I understand, to my satisfaction, the information in the consent form regarding my participation in the research project. All of my questions have been answered to my satisfaction. I have read, understand, and consent to participate in the research described above. By proceeding with the electronic survey, it is understood that I have given such consent.

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Signature of Participant Date